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# THE JOURNAL

## OF

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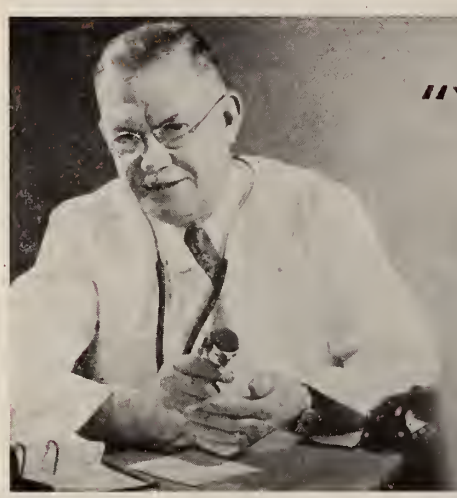
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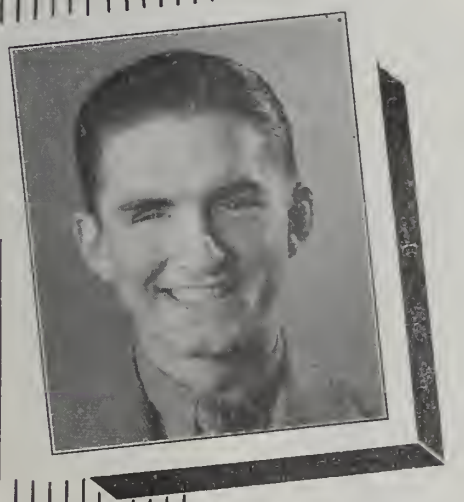


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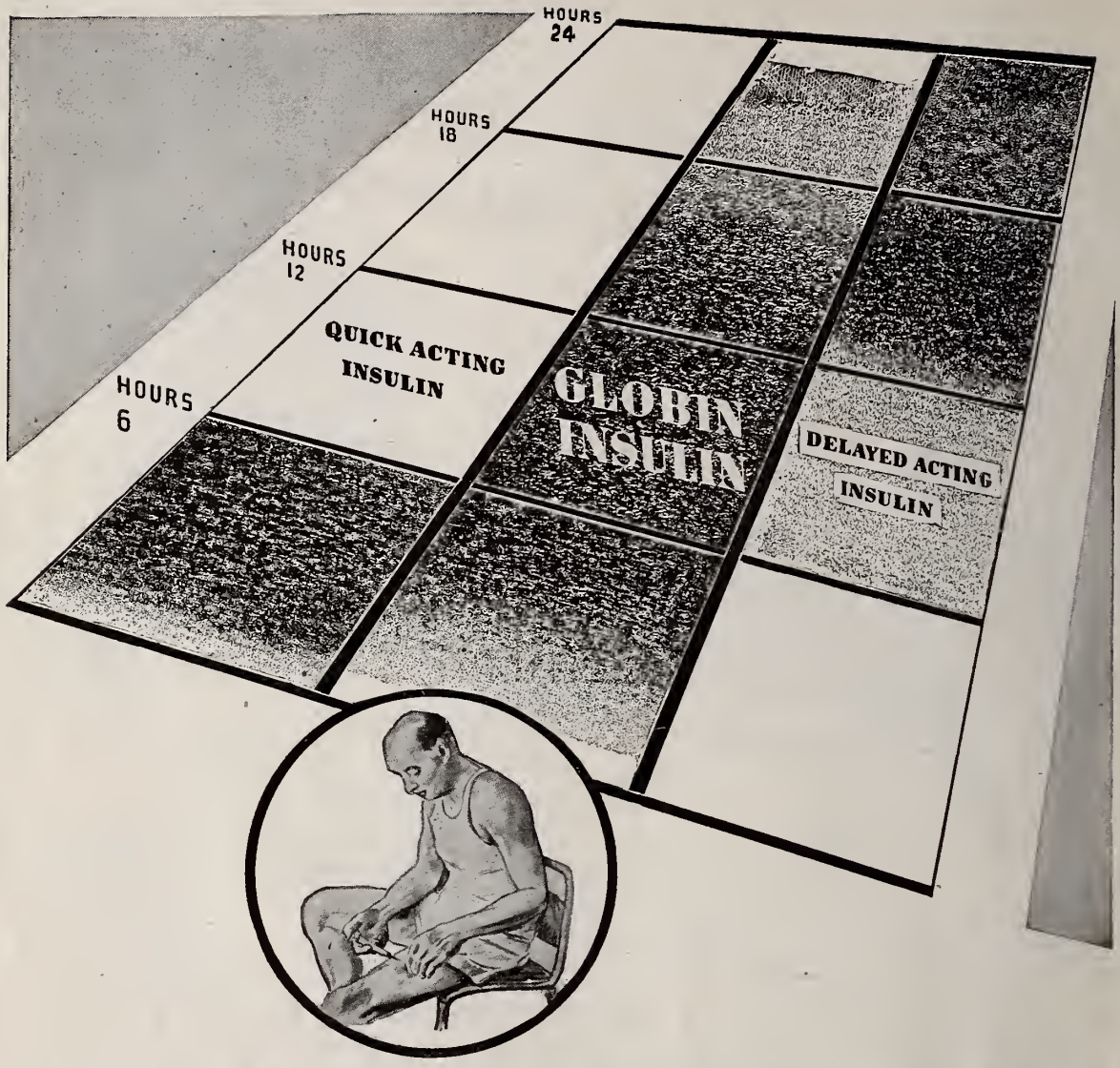
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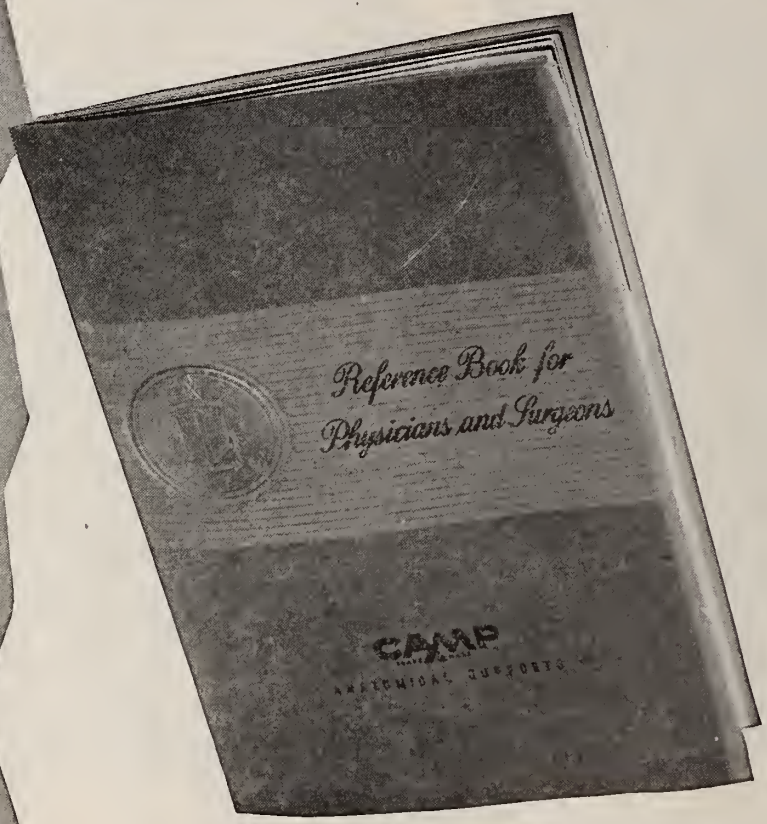
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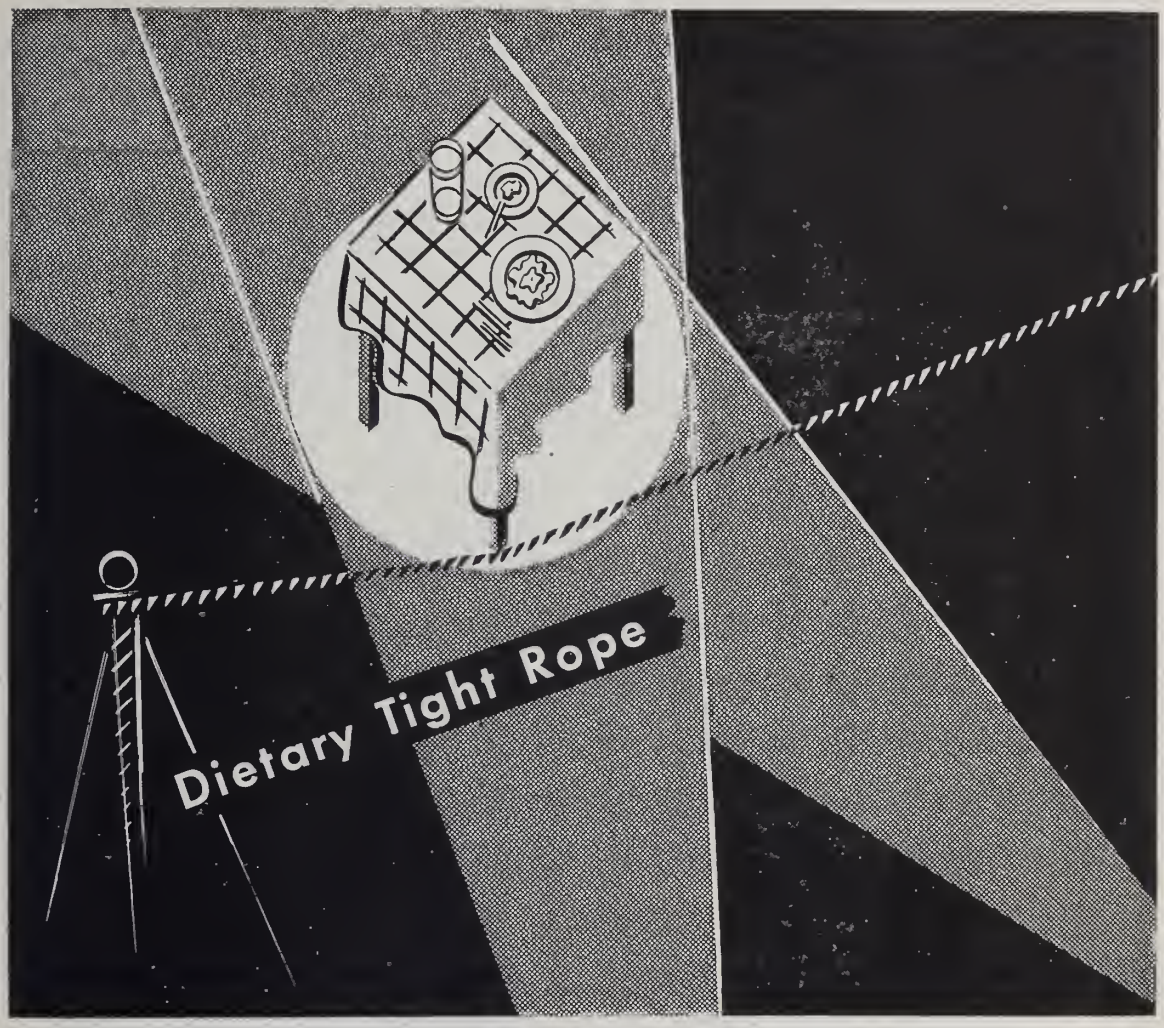
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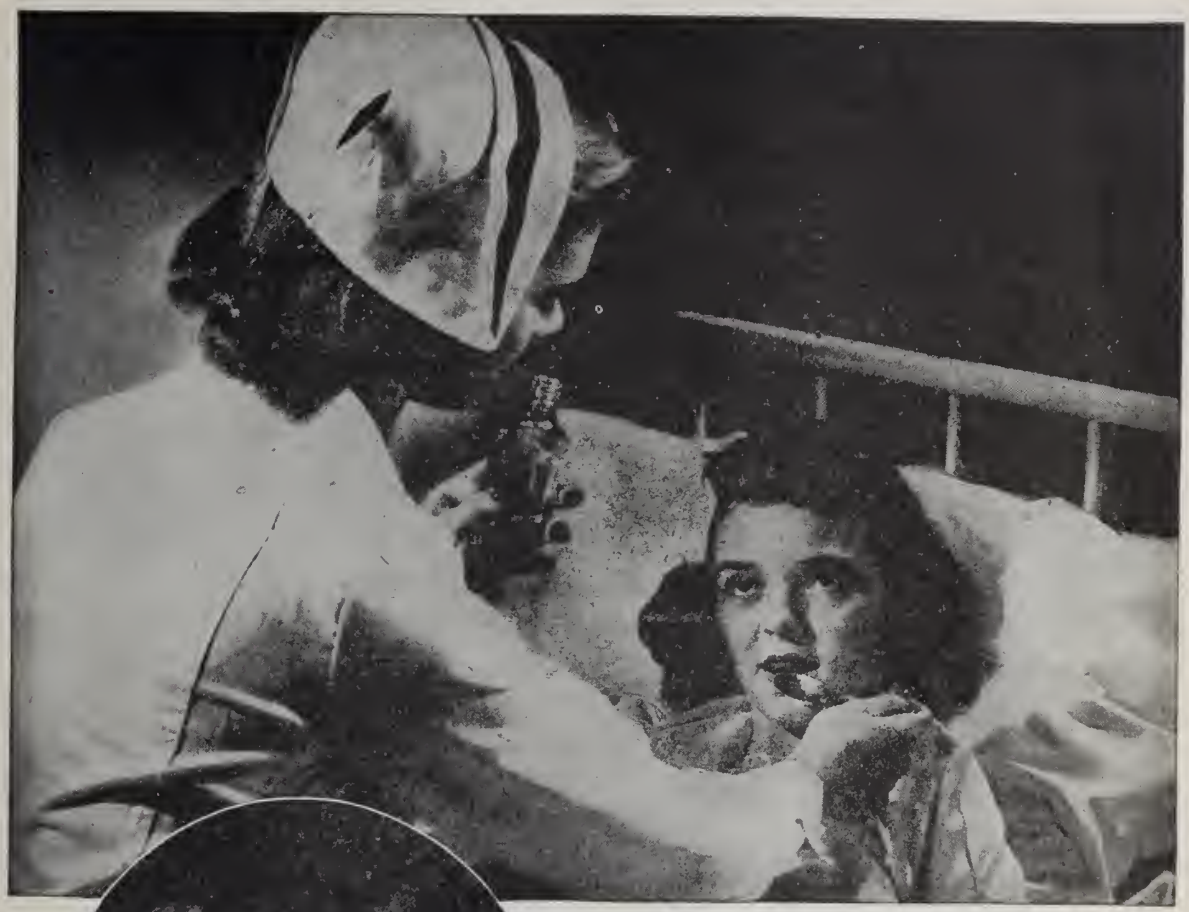
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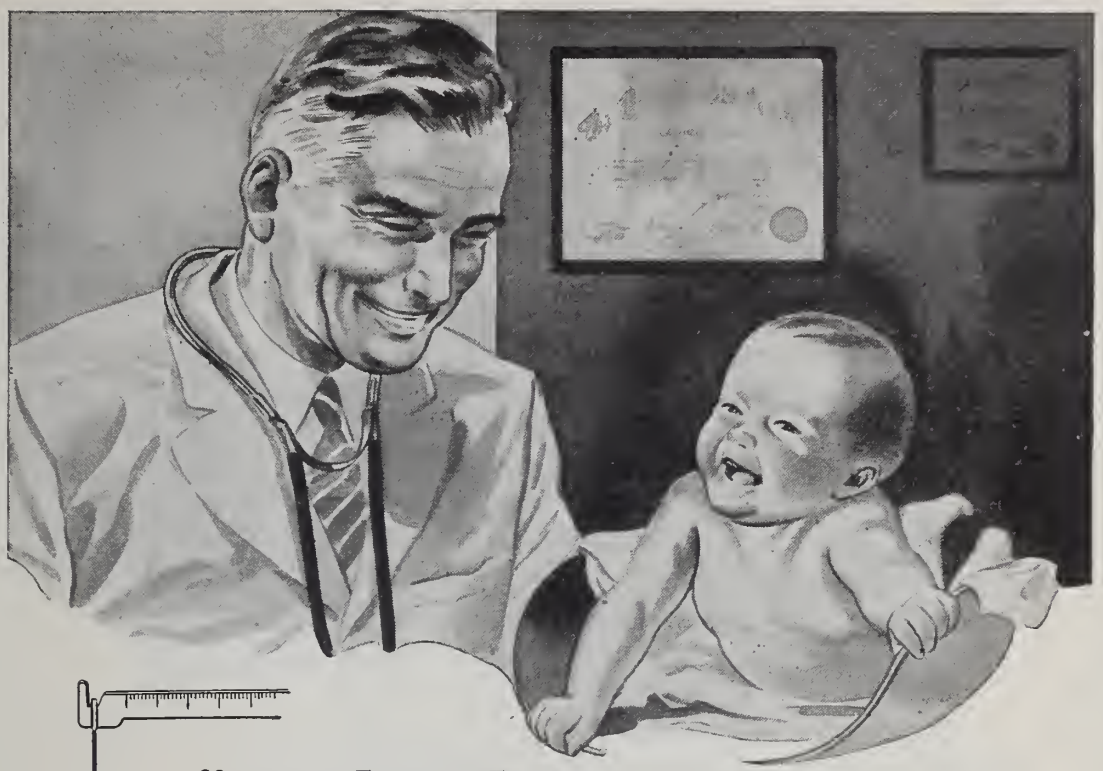
**Gynecological Division**

**JULIUS SCHMID, INC.**

*Established 1883*

**423 West 55th Street New York 19, N. Y.**

A MARK OF Ramses DEPENDABILITY ® U.S. PAT. OFF.



# "another three ounces— just right, young man"

...A familiar statement by physicians prescribing Biolac for infants deprived of human milk.

The protein level of Biolac assures an adequate supply for growth and health, with small, soft curds. The adjusted milk fat facilitates digestion and assimilation with greater freedom from "fat upsets"; and the ample lactose content assures a soft natural stool formation. The adequate proportions of lactose, iron, and vitamins A, $B_1$, $B_2$ and D eliminate the need for time-consuming calculations of extra formula ingredients. Indeed, Biolac (supplemented with vitamin C) provides *completely* for infant nutritional requirements throughout the bottle period.




*Easily calculated... Quickly prepared. 1 fl. oz. Biolac to 1½ fl. oz. water per pound of body weight.*

BORDEN PRESCRIPTION PRODUCTS DIVISION
350 MADISON AVENUE • NEW YORK, 17, N. Y.

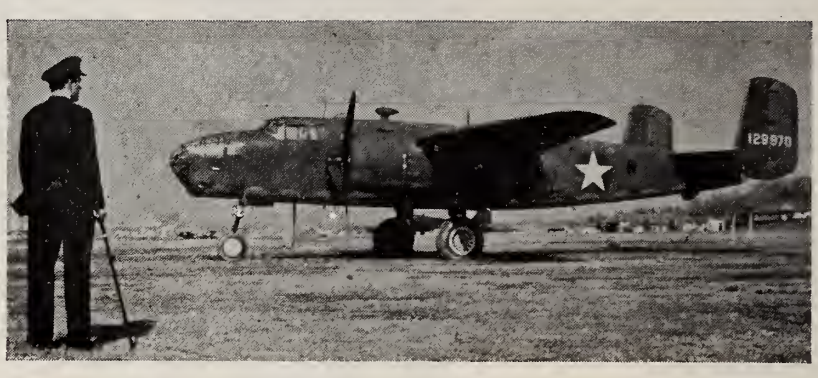
*Biolac is a liquid modified milk, prepared from whole and skim milk, with added lactose, and fortified with vitamin $B_1$, concentrate of vitamins A and D from cod liver oil, and iron. Evaporated, homogenized, and sterilized, vitamin C supplementation only is necessary. Biolac is available in 13 fl. oz. cans at all drug stores.*

ACCEPTED AMERICAN MEDICAL ASSN.

**Biolac**—"BABY TALK" FOR A GOOD SQUARE MEAL

# IN WAR AS IN PEACE - - -

## HANGER ARTIFICIAL LIMBS RESTORE MEN TO LIVES OF ACTIVITY AND USEFULNESS



**Among those in the Armed Forces to whom Hanger Limbs have been supplied in recent months are:**

. . . A Major in the Army Air Forces (see above)
. . . a Lt. Comdr. in the U. S. Navy
. . . a Colonel in the U. S. Army
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. . . a United States Marine
. . . United States Merchant Seamen
. . . Seamen-First Class, U. S. Navy
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**PERFECT FIT — COMFORT and PERFORMANCE**

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*With this in hand*




*The Cardiologist is assured of*

Dependability in Digitalis Administration

Being the powdered leaves made into
physiologically tested pills,
all that Digitalis can do, these pills will do.

*Trial package and literature sent to physicians on request.*

DAVIES, ROSE & COMPANY, Limited

Manufacturing Chemists, Boston 18, Massachusetts

D14



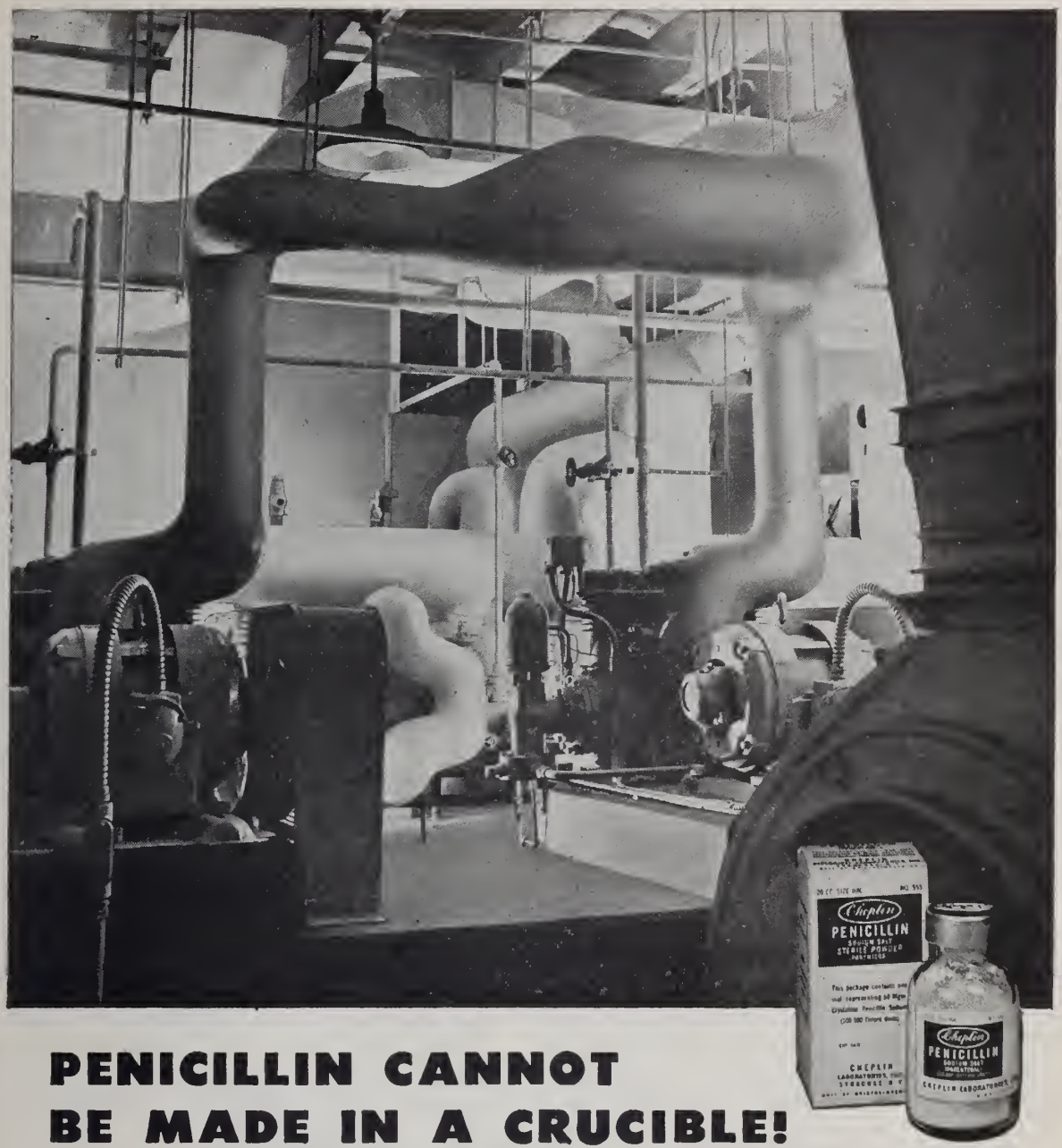
# *1895* X-RAY'S SEMICENTENNIAL *1945*

1895! Chronicled one of the world's greatest scientific discoveries, which brought immortal fame to modest William Conrad Roentgen, University of Wurzburg physicist. Instinctively a scientist, he investigated a phenomenon of light observed while experimenting with an electrically-charged vacuum tube. Today, mankind, in profound gratitude, commemorates Roentgen's contribution—*the X-ray.*

This year, we at G. E. X-Ray also celebrate the 50th Anniversary of the founding of Victor Electric Company (presager of our present organization) by those two well-known pioneers, the late Mr. C. F. Samms, and Mr. J. B. Wantz who, as Consulting Engineer, continues a notable career.

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# PENICILLIN CANNOT BE MADE IN A CRUCIBLE!

Bring back Paracelsus and his crucibles today... show him the clinical picture of Penicillin... take him on a trip through a great Penicillin plant like that of Cheplin Laboratories. What would he think? Your guess is as good as ours!

Just as strides in clinical medicine have been unmeasurable since Paracelsus' time, so too have been the strides in mass-manufacture and plant-investment. In the Cheplin plant at Syracuse, for instance, there are alone thirty miles of pipe needed to make this new "wonder-drug."

Who can state Medicine and the Pharmaceutical Manufacturer aren't working together for a better post-war world? And Cheplin is doing its bit!

**CHEPLIN**
**LABORATORIES INC.**
(UNIT OF BRISTOL-MYERS COMPANY)

**SYRACUSE • NEW YORK**



# IN THE SHORTENING OF *Convalescence*

More than so-termed tonics and restoratives, Ovaltine can be of material aid in shortening the period required for the return of strength and vigor following recovery from infectious or prolonged illnesses. During the acute stages of febrile diseases, when the patient's nutritional intake is low, while requirements are higher than normal, many metabolic deficits are developed. These can be made good only by a high intake of essential nutrients during the recovery period, for only after these nutritional deficits are wiped out can former strength and well-being return.

Ovaltine offers many advantages as a nutritional supplement to the diet of convalescence. This delicious food drink is rich in needed minerals, vitamins, and biologically adequate proteins. Its appealing taste invites consumption of three or more glassfuls daily. Its notably low curd tension encourages rapid gastric emptying, an important factor in maintaining good appetite.

**THE WANDER COMPANY, 360 N. MICHIGAN AVE., CHICAGO 1, ILL.**




*Ovaltine*

Three daily servings of Ovaltine, each made of ½ oz. Ovaltine and 8 oz. of whole milk,* provide:

| | | | |
|---|---|---|---|
| PROTEIN | 31.2 Gm. | VITAMIN A | 2953 I.U. |
| CARBOHYDRATE | 62.43 Gm. | VITAMIN D | 480 I.U. |
| FAT | 29.34 Gm. | THIAMINE | 1.296 mg. |
| CALCIUM | 1.104 Gm. | RIBOFLAVIN | 1.278 mg. |
| PHOSPHORUS | .903 Gm. | NIACIN | 7.0 mg. |
| IRON | 11.94 mg. | COPPER | .5 mg. |

*Based on average reported values for milk.

# *Nothing Has Been Changed:*

**NATURAL SOURCE . . . QUALITY . . . PALATABILITY . . . PRICE**

The natural vitamin A and vitamin D of time-proved cod liver oil itself—in the proportions typical of U.S.P. cod liver oil—are provided today, as for many years, in the three convenient dosage forms of

## *White's* COD LIVER OIL CONCENTRATE

**For infants, antirachitic prophylactic dosage of White's Cod Liver Oil Concentrate *still* costs less than a penny a day. Council-accepted, time-tested, widely prescribed—and promoted, without deviation of any kind, to the Medical Profession alone.**

ACCEPTED AMERICAN MEDICAL ASSN Council on Pharmacy and Chemistry

*Available in:*

Liquid—for drop dosage to infants
Tablets—for youngsters and adults
Capsules—for larger dosage

**Council-accepted. White Laboratories, Inc., Pharmaceutical Manufacturers, Newark 7, N. J.**



*White's* PRESCRIPTION *vitamins*




## MODERN • SIMPLE • SAFE • ETHICAL

*It gives uniformly good results*

• A powdered, modified milk product especially prepared for infant feeding, made from tuberculin tested cows milk (casein modified) from which part of the butter fat is removed and to which has been added lactose, olive oil, cocoanut oil, corn oil, and fish liver oil concentrate.

*One* level tablespoonful of the Similac powder added to each *two* ounces of water makes 2 fluid ounces of Similac. The caloric value of the mixture is approximately 20 calories per fluid ounce.

ACCEPTED AMERICAN MEDICAL ASSN. Council on Foods

★ ★ **SIMILAC** } **SIMILAR TO BREAST MILK** ★ ★

M&R DIETETIC LABORATORIES, INC. • COLUMBUS 16, OHIO

# Office Hours—*24 hours a day*

● Battle front or home front—the story is the same: There aren't enough hours in the day.

It may be a new offensive in the far-off Pacific with its inevitable toll of casualties; it may be an epidemic in a crowded defense area here on the home front—but *never* in history of man has the medical profession carried such a responsibility . . . carried it so magnificently.

But the reward is great. Victory over the aggressors, yes, certainly. And beyond that, victory over an enemy stronger than Germany or Japan. Because terrible though war is, it is the laboratory out of which will come new knowledge to benefit mankind for years to come.








R. J. Reynolds Tobacco Company, Winston-Salem, N. C.

NO ONE more than the busy doctor deserves that precious moment of relaxation . . . the pleasure of a cigarette. Likely as not it will be a cool, flavorful Camel—the favorite cigarette with men in all the services, according to actual sales records.

**CAMELS** *Costlier Tobaccos*




"FIGHT INFANTILE PARALYSIS • JANUARY 14th—31st"



*for Infants and Children*

MILK DIFFUSIBLE *Vitamin* D PREPARATION

DRISDOL in Propylene Glycol makes it possible to secure the benefits obtainable from combining vitamin D with the daily milk ration. This preparation is simple, convenient and easy to use, and relatively little is required for prophylaxis and treatment of rickets—*only two drops daily.*

*does not float on milk*
*does not adhere to bottle*
*does not have a fishy taste or odor*

WINTHROP

ACCEPTED AMERICAN MEDICAL ASSN Council on Pharmacy and Chemistry

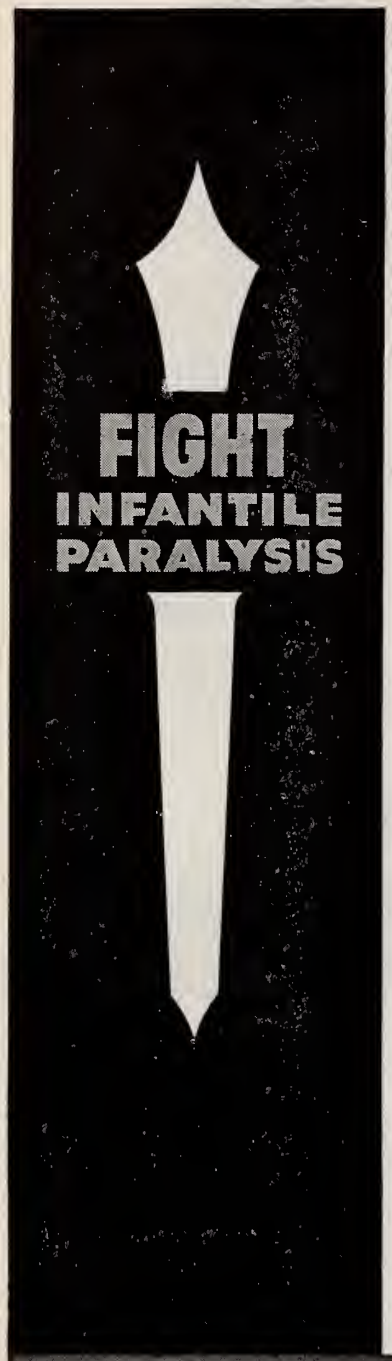
Drisdol in Propylene Glycol—10,000 units per Gram—is available in bottles containing 5 cc. and 50 cc. A special dropper delivering 250 U.S.P. vitamin D units per drop is supplied with each bottle.

**WINTHROP CHEMICAL COMPANY, INC.** NEW YORK 13, N. Y.
Pharmaceuticals of merit for the physician WINDSOR, ONT.

**Drisdol** *in* **Propylene Glycol**

Reg. U. S. Pat. Off. & Canada

*Brand of*
Crystalline Vitamin $D_2$
from ergosterol




# FIGHT INFANTILE PARALYSIS

This plea keynotes the great humanitarian struggle waged unceasingly by the National Foundation for Infantile Paralysis since its inception in 1938 . . . and climaxed each January by an intense public awareness and support campaign.

The vast scope of the battle against infantile paralysis — involving the time, skill and knowledge of our finest doctors and scientists — cannot be comprehended by the majority of people. However, so deep is the desire of Americans to see the obliteration of this dread disease, that they have to date contributed millions of dollars through annual March of Dimes appeals for research purposes alone.

Recognizing the importance of the work of the National Foundation, Rexall Drug Stores proudly join with the American people in support of the 1945 March of Dimes, January 14—31.

**UNITED DRUG COMPANY**

**Boston • St. Louis • Chicago • Atlanta**
**San Francisco • Los Angeles • Portland**
**Pittsburgh • Fort Worth • Nottingham • Toronto**

*PHARMACEUTICAL CHEMISTS—MAKERS OF TESTED-QUALITY PRODUCTS FOR MORE THAN 41 YEARS*

Rexall
DRUGS

# SPENCER BREAST SUPPORTS

## FOR PRE-NATAL AND NURSING



*Spencer Maternity Breast Support*



*Spencer Nursing Breast Support*

Each Spencer Breast Support for pre-natal wear, like *all* Spencer Supports, is *individually designed* for the one patient who is to wear it, to lift and hold breasts in natural, healthful position, without compression.

It improves circulation—protects delicate inner tissues—helps prevent outer skin from stretching and breaking—aids breathing—improves appearance—encourages erect posture. Easily adjustable to increasing development.

Painful, engorged breasts are often relieved by a Spencer, as it allows veins to empty easily. (A further advantage is gained later in increased milk supply from equalization of circulation during pregnancy.)

### Guards Against Caking and Abscessing

The Spencer Breast Support for nursing mothers provides protection against caking and abscessing. Closes in front for nursing convenience.



*Spencer Sleeping Breast Support*

### Spencer Sleeping Supports

are prescribed to continue day-time treatment during night hours. Protects breasts against crushing—aids breathing.

For service look in telephone book under Spencer corsetiere or write direct to us.

**MAY WE SEND YOU BOOKLET?**

**SPENCER** *INDIVIDUALLY DESIGNED*

**Abdominal, Back and Breast Supports**

SPENCER INCORPORATED,

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In Canada: Rock Island, Quebec.

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Please send me booklet, "How Spencer Supports Aid The Doctor's Treatment."

..... M.D.

Address ..... D-1

# *Post-Surgical Starvation*

with its wastage of body tissues, especially tissue and plasma protein, "begins almost at once after protein is omitted from the diet." Hence it is recommended* that meat and other protein foods be added to the diet as soon as possible after surgery. Meat is not only rich in protein, but its protein is of highest quality, able to meet every protein need.

*"Surgeons are accustomed to attribute most of the postoperative weakness or asthenia to the operative procedure without realizing that much of it may actually be due to starvation, particularly deprivation of protein . . . the fall in plasma albumin begins with the very onset of a protein deficient diet . . . Solid food, as eggs and meat, should be added as soon as possible. Most postoperative patients can eat food much earlier than they are usually permitted to." Elman, R.: Acute Starvation Following Operation or Injury: With Special Reference to Caloric and Protein Needs, Ann. Surg. 120:350-361 (Sept.) 1944.

ACCEPTED AMERICAN MEDICAL ASSN. Council on Foods and Nutrition

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

**AMERICAN MEAT INSTITUTE**

**MAIN OFFICE, CHICAGO . . . MEMBERS THROUGHOUT THE UNITED STATES**




# *Walker vitamins are good vitamins*

. . . **Good** for physicians to prescribe because they fill real therapeutic needs with efficiency, and conform to the highest ethical standards of quality. **Good** for patients to take because careful laboratory control assures consistent uniformity of vitamin potencies, and because they are convenient to take. **Good** also, because they offer physician and patient alike, pharmaceutically elegant vitamin preparations at commendably low prices.

**COUNCIL ACCEPTED TABLETS**

**Thiamine Hydrochloride**
(1 Mg., 3 Mg., 5 Mg., 10 Mg.)

**Riboflavin**
(1 Mg., 5 Mg.)

**Ascorbic Acid**
(25 Mg., 50 Mg., 100 Mg.)

**Niacin**
(25 Mg., 50 Mg., 100 Mg.)

**Niacinamide**
(25 Mg., 50 Mg., 100 Mg.)

**SOLUTIONS**

**Solution Thiamine Hydrochloride (Oral)**
(100 I.U. per drop)

**Concentrated Oleo A-D Drops**
(2000 I.U. A and 300 I.U. D per drop)

**CAPSULES**

**Oleo Vitamin A Capsules 25,000 I.U.**
**Nexavitamin U.S.P.**

*Walker*

**VITAMIN PRODUCTS, INC.**
**MOUNT VERNON · NEW YORK**

# IS SODA-BICARBONATE NECESSARY IN SALICYLATE THERAPY

ACCEPTED AMERICAN MEDICAL ASSN Council on Pharmacy and Chemistry

RARE CHEMICALS

To be effective, the treatment of acute rheumatic fever must maintain a high salicylate level in the blood.[1] When massive doses of sodium salicylate are given by mouth, an undesirable side effect—gastric distress—is frequently encountered. To relieve this effect, equal amounts of sodium bicarbonate are given. Unfortunately, a decided depression of the blood salicylate level results.[2]

Gastric distress and its required relief by sodium bicarbonate are avoided when Salysal is given, for Salysal is not soluble in the acid medium of the stomach. Furthermore, 100 parts of Salysal provide 124 equivalent parts of sodium salicylate.[3] Thus, smaller doses accomplish the same effect.

*Literature and sample on request*




Tablets, 5 grains, bottles of 50, 250, 1000
Powder, 1 oz. bottles

# SALYSAL

The Salicylic Ester of Salicylic Acid

**FOR A TRULY POWERFUL SALICYLATE THERAPY**


1. Coburn, A. F.: Salicylate Therapy in Rheumatic Fever, Bull. Johns Hopkins Hosp. 73: 435-464 (Dec.) 1943.
2. Smull, K., Wégria, R., and Leland, J.: The Effect of Sodium Bicarbonate on the Serum Salicylate Level, J.A.M.A. *125:* 1173 (Aug. 26) 1944.
3. New and Nonofficial Remedies, 1943, p. 57.


**RARE** CHEMICALS, INC., HARRISON, NEW JERSEY

Today— NESTLÉ'S Lion Brand Milk has a NEW LABEL . . . and a great new value!




# 400 UNITS OF VITAMIN $D_3$*

# PER PINT




## UNDER THIS NEW LABEL

—this new, improved milk replaces NESTLÉ'S Lion Brand

Today—to meet a recognized need—Nestlé's has produced an improved evaporated milk with *greatly increased Vitamin D.*

*25 USP units of IRRADIATED 7-DEHYDROCHOLESTEROL have been added to each fluid ounce—so that this *new* Nestlé's Milk supplies 400 USP UNITS OF VITAMIN $D_3$ per reconstituted quart.

This improved product is now on grocers' shelves under the *new label* (shown above). The name Nestlé's on this label is, *as always,* your guarantee that there's no finer evaporated milk. *Fortification with Vitamin $D_3$ does not alter this milk's flavor or destroy any of its natural vitamins.*

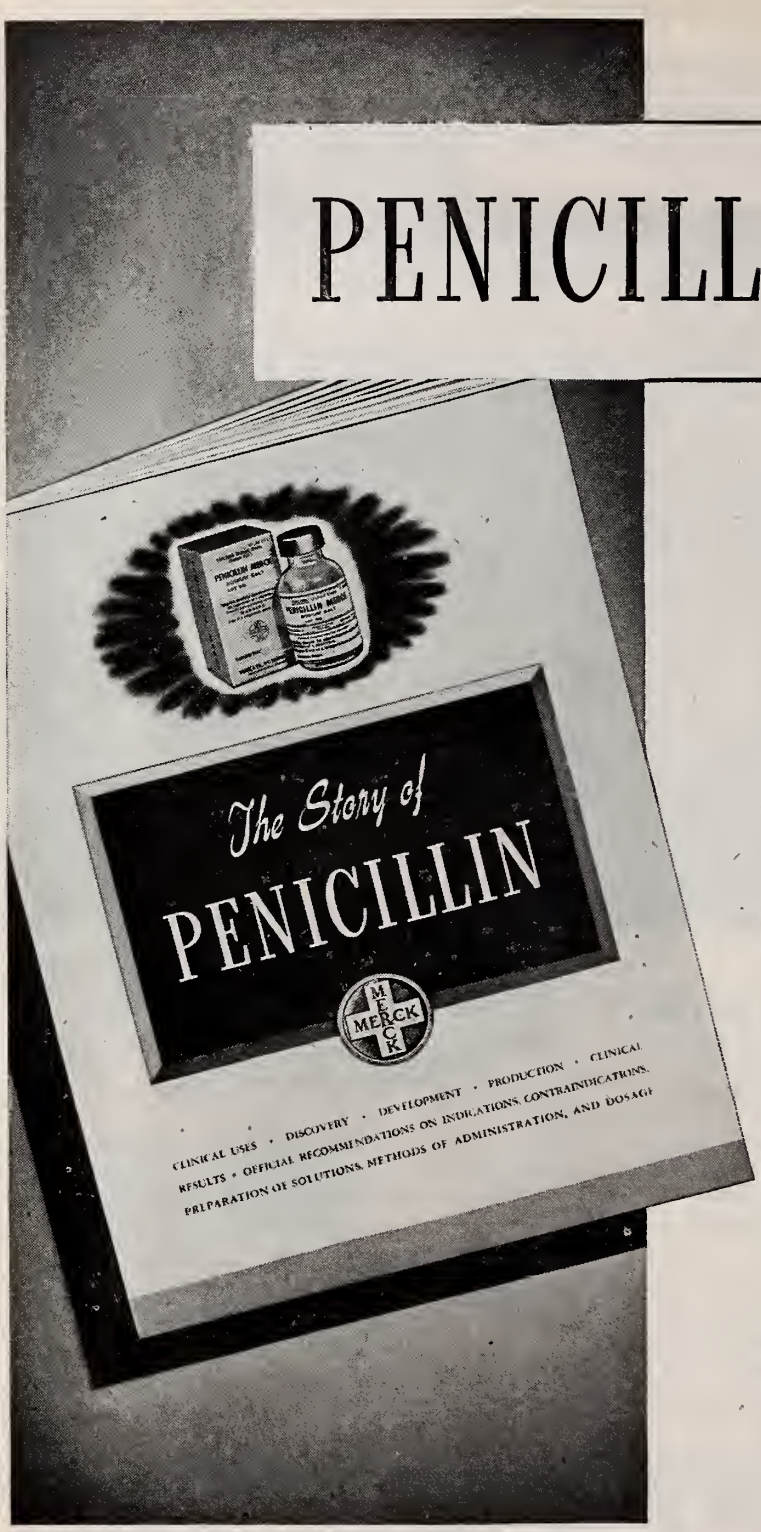
So the extra advantages of NESTLÉ'S Evaporated Milk will be available to everyone—despite the increase in Vitamin D, there has been *no increase in price.*

No feeding instructions furnished to the laity.

**NESTLÉ'S MILK PRODUCTS, INC.**

**155 E. 44th St.— NEW YORK 17, NEW YORK**

# PENICILLIN MERCK




***This 32-page, illustrated brochure, containing up-to-date and comprehensive information on the clinical use of Penicillin, will be sent to you on request.***

THE discovery, production, and clinical evaluation of Penicillin constitute a signal advance in medicine's relentless warfare against disease.

Thoroughgoing experience and established leadership in organic research, development, and production have been determining factors in the achievement of large-scale Penicillin production by Merck & Co., Inc.

Penicillin Merck meets the recognized high standard of quality established for all Merck products. It is subjected to repeated tests and control procedures throughout every step of the production process, and the finished product is assayed, tested, and approved under rigid standards established by the Food and Drug Administration and by the Merck Analytical Laboratories.

As a pioneer in Penicillin research, development, and large-scale manufacture, Merck & Co., Inc. will continue to expand production, with the objective of supplying adequate quantities for civilian medical needs, as well as for our Armed Forces.




**MERCK & CO., Inc.** *Manufacturing Chemists* **RAHWAY, N. J.**

*In Canada:* Merck & Co., Ltd., Montreal and Toronto

# *Sleep, baby, sleep*






BABY has had a good lunch and is sleeping comfortably, thanks to the flocculent, easily digested milk curds produced by 'Dexin'. Nor is it likely that distention, colic and diarrhea will disturb baby's sleep, for the high dextrin content diminishes intestinal fermentation.

Mother is happy because 'Dexin' is so easy to prepare. It is readily soluble in hot or cold milk, and is so palatable without excess sweetness that baby takes other bland supplementary foods willingly. 'Dexin' gives mother extra time for herself. Containers of 12 ounces and 3 pounds. 'Dexin' Reg. Trademark

*Literature on request*

*'Dexin' does make a difference*

COMPOSITION

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| Dextrins . . . . | 75% |
| Maltose . . . . | 24% |
| Mineral Ash . . . | 0.25% |
| Moisture . . . . | 0.75% |

Available carbohydrate 99%
115 calories per ounce
6 level packed tablespoonfuls equal 1 ounce

'Dexin'

HIGH DEXTRIN CARBOHYDRATE

ACCEPTED AMERICAN MEDICAL ASSN.

BURROUGHS WELLCOME & CO. (U.S.A.) INC.
9-11 East 41st Street, New York 17, N. Y.



# Preoperative Calm

ALTHOUGH many of the derivatives of barbituric acid have a generic resemblance in their principal action, there are significant differences which establish certain compounds in special clinical fields. For example, 'Sodium Amytal' (Sodium Iso-amyl Ethyl Barbiturate, Lilly), while frequently prescribed for insomnia, has been found particularly useful as a preanesthetic hypnotic. Given preoperatively it serves to allay fear and apprehension, improves the patient's mental attitude, thus facilitating surgical procedure. 'Sodium Amytal' is also widely employed in obstetrics. In recommended dosage it is capable of producing amnesia without prolonging dilatation of the cervix or interfering with the strength or frequency of uterine contractions.

ELI LILLY AND COMPANY
Indianapolis 6, Indiana, U.S.A.

Lilly

Volume 42
Number 1



# THE JOURNAL
## OF
# THE MEDICAL SOCIETY OF NEW JERSEY

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Direction of the
Committee on Publication




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In Active Service A. U. S.

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Single Copies, 30 Cents

# EDITORIALS

## SOCIAL HYGIENE DAY

Social Hygiene Day this year falls on Wednesday, February 7th. There is little question that this will be a day of unusual significance in the annals of the venereal disease control campaign. The pattern of the wartime program is well established and we have now reached a point where we can look forward to the postwar period and make plans for the problems which will confront our State at that time. There are many reasons to believe that those problems will be large and thorny and that skillful planning and vigorous coördinated effort will be needed to prevent a recurrence of the venereal disease epidemic which swept the world following the last war.

One question mark particularly looms large; that is, the question of whether it will be possible to maintain the interest of the public in venereal disease control and prevent a slashing of governmental funds for this purpose when there is no longer need for protection of the armed forces and when governmental bodies become preoccupied with economizing. Will our people again be penny wise and pound foolish, with the inevitable result of another enormous crop of syphilitics to inhabit our institutions and relief rolls?

During the war a number of advances have been made in venereal disease control work. Organized prostitution has been reduced to a minimum and in many areas progress has been made in dealing with sexual delinquency. Furthermore, facilities for utilizing the new rapid treatment methods for early infectious syphilis have been greatly extended. These rapid treatment methods, whereby the patient with early syphilis can be cured in one or two weeks, are rapidly replacing the year and a half to two-year schedules under which 75 per cent of patients lapse treatment before attaining permanent noninfectiousness. At the present writing there is hope that penicillin will revolutionize the management of both syphilis and gonorrhea.

Control measures in the military forces, consisting mainly of treatment, education and prophylaxis, are so effec-

tive that rates of infection are less than half of what they were during the first world war. Unprecedented coöperative relationships have been developed between the military forces and civilian health authorities. In addition, large numbers of Army and Navy physicians have had an opportunity to observe and participate in modern venereal disease control work and have seen what can be accomplished by means of coöperation with public health officials. They have observed the value of interviewing patients to learn from whom they acquired their infections and to whom they may have transmitted them, and they have observed how referrals of this information to health departments result in the finding of large numbers of infectious venereal disease patients, many of whom would otherwise remain undiscovered and continue to spread their infections. These physicians, who are now concerned with protecting the armed forces against the venereal diseases, will presumably be just as concerned in peacetime with the protection of civilians against the spread of venereal diseases. These physicians will be our greatest asset in all postwar programs of venereal disease control.

Simultaneously, more and more civilian physicians have established coöperative relationships with public health nurses employed by civilian health agencies for venereal disease work. They call them in whenever they have new venereal disease cases for the purpose of interviewing these patients for contact information and doing the "shoe leather epidemiology" which is so effective in discovering the hidden cases of infectious venereal diseases and bringing them to treatment. In New Jersey these public health nurses are supplementing the activities of physicians and clinics so effectively that our State is gaining the reputation among public health workers of having one of the best venereal disease control programs in the country.

These are substantial gains in the battle against venereal diseases, but can we maintain them in the postwar period and continue to progress? Walter Clarke, M.D., Executive Director of the American Social Hygiene Association, said recently: "The experience of World War One suggests that following the present war, there may occur:

"First—a let-down in efforts to repress prostitution and promiscuity and a recrudescence of flagrant prostitution conditions in many cities.

"Second—an increase in the prevalence of syphilis and gonorrhea growing out of the above conditions and similar let-downs in finding, holding and curing cases.

"Third—unsound financial and administrative restrictions which would result in eliminating trained personnel and otherwise handicapping essential public health, medical, social and educational activities at the Federal, state and local levels."

Dr. Clarke goes on to say that: "Among other factors that may influence the postwar venereal disease rates, unless equivalent or substitute measures adapted to civil conditions and authority are instituted, we may mention:

"1. The ending of the May Act by statutory limitation;

"2. The withdrawal of military police who stop men who are now soldiers or sailors from entering dangerous dives;

"3. The loss of periodic medical inspections which now discover among men in the armed forces new cases of syphilis and gonorrhea.

"The glamour of war will be gone. The great influence of morale building and sustaining activities will cease for men and women leaving the military services. Many of them, feeling a great sense of let-down, confusion and uncertainty following war and its disciplines and adventure, may be expected to take chances and forget the instruction and advice they have received."

These statements deserve the careful

consideration of all who are seriously concerned with protecting our people against the ravages of venereal diseases. To prevent a serious postwar epidemic of these diseases it will be necessary to decide in our own minds and to convince the public that it is just as important to protect the civilian population as it is to protect the armed forces. An aggressive program of public education will be needed in order that public opinion may be aroused to oppose any restriction of the medical, public health, law enforcement, social welfare or educational aspects of the venereal disease control program. Above all, the physicians and health departments of New Jersey must coöperate to provide an integrated program of treatment, case-finding, case-holding and education. Each physician in New Jersey is urged to request the State Health Department to have the public health nurse who is doing venereal disease work in his area call on him to explain the services which the Health Department can offer him.

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## THE A. M. A. BUREAU OF INFORMATION

The Bureau of Information created as a unit of the American Medical Association by its Committee on Post War Medical Service will interest particularly our members in military service. It is administered by Lt. Col. Harold Leuth, M.C., Liaison Officer of the War Department at A. M. A. Headquarters.

The activities of the Bureau are carried on primarily to assist returning medical officers in their educational, licensure and placement problems. The Bureau will request the assistance of State and County Societies in this work.

In addition to providing returning medical officers with information concerning educational opportunities and information concerning state licensure, the Bureau as a result of extensive surveys will provide information on the medical, social, economic, financial and other phases of community life which will assist returning officers in making a wise selection of a permanent location in which to practice medicine.

A tabulation of the first 11,019 questionnaires returned by men in service indicates that the older men desire short refresher courses while the younger men desire resident training of one to three years. The Bureau with the assistance of the Council on Medical Education and Hospitals will maintain an inventory of hospital and medical school facilities so that the veterans can be promptly informed of all available educational opportunities.

To assist veterans in establishing permanent practices the Bureau will use the counties of the United States as the basic unit in providing information. A form known as the "County Information Sheet" pertaining to each County will be maintained by the Bureau and copies made available to any veteran making inquiry concerning a location within any respective County. State and County Societies will be requested to furnish much of this information and to carry on correspondence with veterans interested in locating within their respective States or Counties. The Form will contain information concerning the population, number of physicians, important cities and towns, medical and health facilities, hospital facilities, economic and financial conditions, climatic and social conditions, schools, churches, amount of retail sales, types of highways, number and types of dwellings, etc., with space allowed for special information contributed by State and County Societies.

This is a new Bureau of the A. M. A. providing an entirely new type of serv-

ice. It is the basic administrative unit of our post-war planning program. Its success will depend largely upon the coöperation received from State and County medical Societies.

In closing this presentation of this Bureau before the Meeting of Secretaries and Editors, Col. Leuth appealed for the complete coöperation of organized medicine in this work, his closing remarks being, "Repeatedly, it is said that medicine 'can keep its own house and manage its own affairs'. The successful operation of the Bureau of Information presents a real challenge to all of us to prove our ability to provide for our own."

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## THE CRITICAL NEED FOR NURSES

With casualties increasing by many thousands each week, our armed forces find themselves in critical need for additional nurses.

This is a challenge to our nurses, physicians and the general population. Nurses have been slow in appreciating their obligations; physicians have been hesitant in appreciating the need, and the necessity for economical use of nursing services for their patients; and the general population provided with an abnormal income tend to indulge their desire for special nursing as a luxury. Despite all arguments supporting the need for nursing services at home, there is a greater need if we are to provide the type of care which is due our wounded.

The Nurse Procurement Section of New Jersey Procurement and Assignment Service and New Jersey State Nurses Association appealed to the State Advisory Committee of Procurement for assistance and advice at a meeting held on December 20, 1944.

Briefly the situation is as follows: There are 18,000 registered nurses in New Jersey. About 2,000 have entered military service. Although the current need is critical, only 25 have entered military service from New Jersey in the past month. Two thousand younger nurses are classified as available, of whom about one thousand are employed as general duty nurses in our civilian hospitals.

The recommendations of the Committee are:

1. The acceptance, as a moral obligation, by inactive nurses of part-time or full-time duty in our civilian hospitals in order to make available for military service many of the younger nurses now employed in our hospitals as general duty and special nurses.

2. A twelve-hour day for special duty nurses with proper compensation for extra hours of duty.

3. A limitation of two special nurses for any one patient during any twenty-four-hour period.

4. Group nursing by private nurses for private patients in hospitals.

5. The discontinuation of "luxury nursing" and the limitation of private duty nursing to only those patients who are critically ill and whose recovery would be jeopardized if their nursing care was limited to the services of general duty nurses, the services of community visiting nurses or nursing service provided by members of their own household.

6. That the medical profession, hospitals and the civilian population be informed through medical journals, county medical societies and the lay press of the critical need for additional nurses to provide adequate care of our wounded and the necessity for a more economical use of nursing services by the civilian population.

## PROCUREMENT AND ASSIGNMENT SERVICE

The State Advisory Committee met on December 20, 1944, to consider the following:

1. Intern-Resident quotas for the nine-month period beginning July 1, 1945.

2. Report on medical manpower by Counties in New Jersey.

3. The problem of procuring additional nurses for the Army.

A. The Committee made no recommendation concerning the intern quota assigned to New Jersey. It is sufficient to meet the needs providing our hospitals can procure their quotas.

The Resident quota was considered inadequate. The Committee recommended changes to be presented to the Intern Committee of the Central Board at its meeting to be held on January 1st.

The quota of commissioned interns eligible to fill the resident quota is not sufficient to provide for all eligible residencies. The Committee recommended that such deferments be approved in the order in which the requests were received in the local office except that teaching residencies approved by the Council on Medical Education be set aside and be filled by deferment of commissioned interns.

B. The Committee agreed that it would not be possible to render a reliable report on medical manpower in our larger counties. It was felt that concerning our smaller counties such information should be obtainable. The report as requested by the Central Board would include the physical capacity of each physician, type of practice, whether or not he made night calls, limited his work to office practice, etc.

C. The problem of nurse procurement is presented elsewhere in this *Journal*.

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## THE IMMEDIATE FUTURE

Present trends indicate that new legislation to provide for a national sickness insurance plan will be introduced during the early weeks of the new Congress which convenes in January.

Predictions are that several bills will be introduced. It is believed that one, and perhaps the most formidable, will originate in the Pepper Committee which is now studying "wartime health and education". Others may originate from the report of the United States Public Health Association, and from the Council on Health of the Congress of Industrial Organization. We may expect one or all of these Bills to be introduced in February or March, 1945.

These new Bills will probably not be the "omnibus" type of Bill as represented by the Wagner-Murray-Dingell Bill of 1944. Instead, they will be limited to legislative provisions for medical care and hospitalization plans. Labor organizations apparently believe that they lost their chance to obtain "sickness benefits" because of inclusion of this provision in a Bill which also included medical care and hospital benefits.

What are we going to do about it? Well, we must guide public opinion, both before and after this legislation is introduced. What we accomplish will be largely the result of the sum-total effort of all individual physicians.

The individual physician is the most valuable asset of the profession in guiding public opinion. He is in the best position to tell the public the story of medicine, its past, its ideals and traditions, its accomplishments and its hopes for the future.

But, the physician must tell the right story and must tell it to the right people. Tell it to your patients, to the leaders in

your community, to your representatives in the State Legislature and National Congress. Get your story out to the general population, who by their majority vote control our national policies.

Tell them why it is necessary to maintain our present framework of medical practice: that the principle of free choice of physician and patient is necessary to promoting personal initiative of the physician, an ethical type of competition and in maintaining high standards of medical care. Convince them that a system of medical practice built upon our present framework, altered by voluntary methods to meet present social needs at a local level is a better system than any theoretical, compulsory, untried system controlled by government bureaucracy. Convince them by your own standards of practice and by your own patient-physician relationship that these things are true.

Present to them the constructive attitude of the profession in seeking a solution for this problem. Discuss with them the platform of the American Medical Association and the program of your own State Society to improve medical care distribution in accordance with the needs of the people of New Jersey.

If we fail to convince the public and our elected representatives in the government that we are right, then we must realize that the sworn duty of our elected representatives in government requires that they take whatever action they deem necessary for the welfare of our people.

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## THE PLATFORM OF THE AMERICAN MEDICAL ASSOCIATION

**Adopted by the House of Delegates, American Medical Association, June 13, 1944**

1. Availability of medical care of a high quality to every person in the United States.

A. In the extension of medical services to all people, the utmost utilization of qualified medical and hospital facilities already established.

B. The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability, including the development and extension of voluntary hospital insurance and voluntary medical insurance.

C. Expansion of public health and medical services consistent with the American system of democracy.

D. The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health and the care of the sick on proof of such need.

E. The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.

F. The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.

G. The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.

H. The establishment of an agency of federal government under which shall be coördinated and administered all medical and health functions of the federal government exclusive of those in the Army and Navy.

See The Journal of the American Medical Association, June 24, 1944, Vol. 125, pp. 574-576.

# ORIGINAL ARTICLES

## ACUTE SEPTICEMIA WITH ADRENAL HEMORRHAGE*

### (Waterhouse-Friderichsen Syndrome)

#### A REPORT OF FOUR CASES WITH TWO RECOVERIES

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This syndrome is characterized by the presence of a fulminating septicemia associated with purpuric or petechial spots on the skin and mucous membranes and hemorrhages of varying degree into the adrenal glands.

HISTORICAL

Voelker in 1894 was the first to describe a case of fulminating illness with purpuric eruption and bilateral adrenal hemorrhage. In those days it was called adrenal apoplexy. In 1901 Graham Little collected 11 similar cases and noted that the bacteriology was negative. In 1911 Waterhouse reported a case of his own and reviewed 15 cases collected from the literature. He claimed that they formed a distinctive clinical picture which had hitherto not been recognized. However, he added nothing to the etiology. MacLagan and Cooke in 1916 were the first to connect the syndrome with the meningococcus. In 1918 Friderichsen reported a case and reviewed the literature. He found in his case a small gram negative diplococcus present on blood culture, but he did not identify the organism. Since then, many additional cases have been reported. In February, 1944, Martland reported 19 cases discovered in a series of 10,000 autopsies performed in the past 13 years at the Medical Examiner's Office of Essex County, New Jersey.

ETIOLOGY

The most common microörganism isolated on blood culture has been the meningococcus, being present in the vast majority of the reported cases. Other organisms occasionally isolated have been the streptococcus hemolyticus, the pneumococcus and the influenza bacillus.

CLINICAL PICTURE

About 70 per cent of the cases reported appeared in children. In the four cases reported here, three were adults, and one a child. The more recent reports have shown a high incidence in adults. The onset is always sudden with fever and chills. Vomiting is frequent. The most characteristic symptom is cyanosis, which is very marked, and many of the cases are first diagnosed as pneumonia. Within a matter of hours after the onset, a rash appears, purpuric at first, the spots getting larger and finally becoming ecchymotic. This rash is present all over the body, and the mucous membranes of the mouth and eyes. Actual hemorrhages may be present in the cornea. The fever rises rapidly and the symptoms of shock supervene: falling blood pressure, rapid thready pulse, dehydration. The blood pressure is low in all cases. This illness is so fulminating that the patient usually dies in less than 24 hours from the onset of the symptoms. For this reason complete studies are usually not done, and only after autopsy are the symptoms correlated with the characteristic pathology.

PATHOLOGY

Laboratory examinations are generally of little value to the patient on account of the rapid course of the disease. The blood culture is positive, the meningococcus being found in the great majority of the cases. However, the blood culture takes at least several days, by which time the patient is either dead or on the road to recovery if the proper treatment has been promptly and vigorously instituted.

* Read at a regular monthly staff meeting at St. Mary's Hospital, Hoboken, N. J., October 19, 1944.

Recently a new diagnostic procedure has been reported by Bernhard and Jordan. These investigators have succeeded in isolating meningococci from smears of the scrapings of purpuric lesions in 27 out of 40 cases, where the organism was present in the blood stream. This may prove a quick and important laboratory test in diagnosis. This test was tried in two of our cases and yielded negative results. Spinal fluid examinations at the beginning are generally normal; later they tend to become abnormal. The leukocyte count is reported as generally high. In our cases one was high and two were within normal limits. Pathologically the outstanding feature has been signs of acute sepsis and hemorrhage into one or both adrenal glands. This has been present in over 95 per cent of all autopsied cases. These findings vary from pinpoint hemorrhages to massive bleeding involving the entire gland. Recently Williams (1942) reported a series of 17 fatal cases, clinically indistinguishable, in which only nine had adrenal hemorrhage at autopsy. He believes that adrenal hemorrhage is but an incident in an explosive disease process which overwhelms all body resistance.

## CASE REPORTS

*Case No. I,* Mrs. E. F., age 43, housewife: This patient was admitted at 10:30 a.m. on March 2, 1944, in a state of confusion and delirium with a temperature of 105° F. and marked general cyanosis and dyspnea. History obtained from the relatives revealed a sudden onset of fever about twelve hours prior to admission. She had been previously well. There was no history of a preëxisting respiratory tract infection.

Physical examination revealed vesicular breathing and unimpaired percussion. A few fine moist râles were heard at both bases. The heart was not enlarged to percussion. The heart sounds were distant but of fair quality. No murmurs were heard. The pulse was feeble and rapid. The blood pressure was systolic 75 and diastolic 40. The abdomen presented no significant findings. The deep and superficial reflexes were physiological. The lips, fingers and toes were cyanotic. The feet were cold and clammy. No petechiae or purpuric areas were present at this time.

A blood culture was taken and followed by the administration of sodium sulfadiazine (2 grams) intravenously. A portable radiographic examination of the chest was negative to lung pathology.

Approximately two hours after admission to the hospital the patient's temperature rose to 107° F. At this time there seemed to be some nuchal rigidity and there was a suggestion of a positive Kernig's sign which prompted a lumbar puncture. A clear spinal fluid, under no increased pressure, was obtained. At the time of the puncture it was noticed that many petechiae and purpuric spots were developing in the skin and conjunctivae. These increased in size until a generalized lividity was present within one hour. The patient died at 3:30 p.m. the same day.

*Laboratory Data:* Blood count—Hemoglobin 14 grams; R. B. C. 4,400,000 per c. mm.; W. B. C. 8,400 per c. mm. Differential count: Polys 53 per cent segmented and 7 per cent non-segmented; lymphocytes 32 per cent; eosinophiles 2 per cent; basophils 1 per cent.

Spinal Fluid—Clear; colorless; cell count 18 cells per c. mm.; differential Polys 28; lymphocytes 72; globulin normal; sugar normal.

Blood culture was positive for meningococcus.

*Summary of the Post-Mortem Examination* (gross anatomical examination done by Dr. H. B. Kaplan): The body was that of a white, well-developed and well-nourished female, 43 years of age, measuring 66 inches in length and estimated to weigh 200 lbs. The scalp was covered with dark hair streaked with grey and there was the usual female distribution of the hair of the body. The skin was livid and everywhere diffusely flecked with petechiae. Both the bulbar and palpebral conjunctivae of the eyes presented petechial hemorrhages. There was a thin, brownish, watery discharge from the nose and mouth.

The meningeal vessels were congested but there was no evidence of fibrin or purulent exudate. The entire brain was congested. There was no hemorrhage.

There was no excess of thymic tissue. The pericardium was smooth and glistening, the pericardial sac contained no excess of fluid. The heart was soft and flabby; it weighed 420 grams. The epicardium was smooth but the endocardium presented scattered petechiae. There were no valvular defects.

Both lungs were free and clear. The right weighed 600 grams, the left 520 grams. The surfaces were deep red and on section, the cut surfaces exuded an excess of a bloody, frothy fluid.

The liver weighed 2160 grams and presented cloudy swelling. The gall-bladder had been previously removed.

The spleen weighed 300 grams and showed congestion.

The pancreas presented no unusual features.

Both adrenals were markedly enlarged and diffusely hemorrhagic.

The kidneys presented cloudy swelling.

The uterus presented many pedunculated fibroids, the adnexa were not remarkable.

The entire gastro-intestinal tract presented no unusual features.

*Microscopical Description:* Sections of the brain, including cerebrum, mid-brain, pons, medulla and cerebellum stained with H. and E. showed edema and congestion. There were a few minute scattered petechiae in the cerebral cortex. The meninges showed congestion but no exudate.

Sections of the myocardium showed toxic myocardosis.

Sections of the lungs showed edema and congestion.

Section of the spleen showed congestion.

Sections of the liver and kidneys showed parenchymatous degeneration.

Sections of the lymph nodes showed edema and congestion.

Sections of the adrenal glands showed diffuse recent hemorrhage. In the cortex degenerated glomeruli and fasciculi were outlined in a matrix of blood, but the medulla was entirely disintegrated. There was no inflammatory exudate.

*Cause of Death:* Acute septicemia associated with hemorrhage of the adrenals (corroborated by antemortem blood culture positive for meningococcus).

*Case No. II,* M. B., female, age 4 years: This child was admitted to the hospital at 11:30 p.m. on March 5, 1944, with a history of onset of illness that afternoon. The first symptom was pain in the legs followed by vomiting, fever, chills and, shortly prior to admission, delirium.

Physical examination on admission revealed general pallor and cyanosis of the lips. The patient appeared extremely toxic. There were petechiae scattered over the trunk, arms and lower extremities. A friction rub was elicited over the precordium. There was some nuchal rigidity. Spinal fluid obtained from a lumbar puncture was clear and not under increased pressure. The temperature was 105.4° F., the pulse 130 and the blood pressure was systolic 70 and diastolic 30. The respirations were very rapid and shallow. Sulfadiazine was given (1 gram) and retained. However, the condition of the child became progressively worse and death occurred at 8:20 a. m. on March 6, 1944.

*Laboratory Data:* No blood count was taken. The urinalysis was normal. A post-mortem blood culture was positive for meningococcus.

*Summary of the Post-Mortem Examination* (gross anatomical examination done by Dr. H. B. Kaplan): The findings were similar to those of Case No. I. The body was that of a well-developed and well-nourished white female child of 4 years of age. There were numerous petechiae and ecchymoses in the skin over the thorax, abdomen, back and extremities, and in the mucous membranes of the hard palate and conjunctivae. The internal examination was limited to an abdominal incision. The adrenals were hemorrhagic, the solid viscera showed congestion and parenchymatous degeneration. The stomach was moderately dilated with fluid, but the intestinal tract was not remarkable.

*Microscopical Examination* showed recent hemorrhage of the adrenals without phagocytosis or inflammatory infiltration.

Sections of the liver, kidneys and spleen confirmed the gross anatomical findings.

*Cause of Death:* Acute meningococcemia associated with hemorrhage of the adrenal glands.

*Case No. III,* Mrs. F. W., age 55, occupation secretary; case of Dr. Eugene Kiely: This patient was admitted via ambulance on May 2, 1944. Temperature 104.5° F., pulse 136 beats per minute, respirations 32 per minute. Friends informed us that she had complained of pains in the back and legs; no other history was obtainable. The patient was stuperous on admission to the hospital and very cyanotic. There was no stiff neck, nor were the reflexes abnormal. The blood pressure was 40 mm. Hg. systolic, 20 mm. Hg. diastolic. Petechiae were present on the conjunctivae and sclerae as well as on the roof of the mouth. Petechiae were also present on the trunk and on the upper and lower extremities. A tentative diagnosis of Waterhouse-Friderichsen syndrome was made, and treatment vigorously instituted. Adrenal cortex extract was given in a dose of 10 c.c. by injection at once, followed by 5 c.c. every 2 hours. Adrenalin 1-1000 solution was given in 1 c.c. doses every 3 hours. Sodium sulfadiazine was given intravenously in sufficient dosage. Plasma was given intravenously as well as saline and glucose. The patient recovered and was discharged 17 days after admission.

*Laboratory Data:* On admission: R. B. C. 4,300,000 per c. mm., W. B. C. 8,900 per c. mm., hemoglobin 12.5 grams. Differential count: Polymorphoneuclears 84 per cent, lymphocytes 10 per cent.

Nose and throat culture for diphtheria bacillus was negative.

Spinal fluid—clear; under no pressure; no cells present. No globulin; normal sugar. Culture of spinal fluid for organisms was negative.

Blood culture—positive for meningococcus.

Scrapings from petechial lesions were examined on a smear and no organisms were found.

A resume of blood pressure readings taken during the first days of the disease is interesting:

| | | Systolic | Diastolic |
|---|---|---|---|
| May 2, 1944 (admission) | a.m. | 40 mm. Hg. | 20 mm. Hg. |
| | p.m. | 54 mm. Hg. | 32 mm. Hg. |
| May 3, 1944 | a.m. | 54 mm. Hg. | 30 mm. Hg. |
| | p.m. | 54 mm. Hg. | 30 mm. Hg. |
| May 4, 1944 | a.m. | 78 mm. Hg. | 50 mm. Hg. |
| | p.m. | 74 mm. Hg. | 52 mm. Hg. |
| May 5, 1944 | a.m. | 88 mm. Hg. | 62 mm. Hg. |
| | p.m. | 88 mm. Hg. | 60 mm. Hg. |
| May 6, 1944 | a.m. | 96 mm. Hg. | 70 mm. Hg. |
| | p.m. | 100 mm. Hg. | 68 mm. Hg. |

*Case No. IV,* Mr. W. B., age 50, occupation city fireman: This patient, referred by Dr. Robert Verdon, was admitted by ambulance on May 20, 1944, at 3:45 p.m. with a temperature of 106° F., pulse rate 140 beats per minute and respirations of 40 per minute. The symptoms began suddenly the same morning with nausea, vomiting, fever, restlessness and stertorous breathing.

Physical examination showed an acutely ill white male, semistuperous with Cheyne-Stokes respirations. The pulse was rapid and thready; petechiae were present in both conjunctivae as well as on the arms and neck. There was no rigidity of the neck, no Kernig or Brudzinski reflex. The pupils were equal. The blood pressure was 75 mm. Hg. systolic, 40 mm. Hg. diastolic. A tentative diagnosis of Waterhouse-Friderichsen syndrome was

made by Dr. Walter Modarelli who saw the case on admission.

*Laboratory Data:* On admission: R. B. C. 4,500,000 per c. mm., W. B. C. 19,000 per c. mm. Differential count: Polymorphonuclears 80 per cent.

Nose and throat cultures were negative for diphtheria.

Smear from scrapings of petechiae showed a few pus cells, no organisms were seen.

Spinal fluid—clear; 5 cells per c. mm.; other tests were normal.

Urine—trace of albumin, otherwise normal.

Blood culture was positive for meningococcus.

*Treatment:* Sodium sulfadiazine was given intravenously in doses of 5 grams in 100 c.c. sterile distilled water. This dose was repeated at frequent intervals. Adrenal cortex 10 c.c. by injection was given at once and then 5 c.c. every 2 hours. Fluids were given by injection 3000 c.c. each day. Adrenalin 1-1000 in 1 c.c. doses was given every 3 hours. After two days the temperature dropped to normal and the blood pressure rose to 148 mm. Hg. systolic and 80 mm. Hg. diastolic. The patient was fully conscious and rational now. The dose of cortical extract was reduced sharply and later totally discontinued. The patient improved rapidly and was discharged 21 days after admission. The sulfadiazine level in the blood was 6.8 mg. per 100 c.c. four days after admission and 12.9 mg. per 100 c.c. 10 days after admission, when it was discontinued. An electrocardiogram taken before discharge showed normal tracing.

A resume of the blood pressure readings in this case is interesting:

| | | Systolic | Diastolic |
|---|---|---|---|
| May 20, 1944 | | | |
| (admission) | 3:45 p.m. | 75 mm. Hg. | 40 mm. Hg. |
| | 11:00 p.m. | 70 mm. Hg. | 45 mm. Hg. |
| May 21, 1944 | .....a.m. | 80 mm. Hg. | 60 mm. Hg. |
| | p.m. | 110 mm. Hg. | 40 mm. Hg. |
| May 22, 1944 | .....a.m. | 110 mm. Hg. | 70 mm. Hg. |
| | p.m. | 148 mm. Hg. | 80 mm. Hg. |
| May 23, 1944 | .....a.m. | 130 mm. Hg. | 80 mm. Hg. |
| | p.m. | 140 mm. Hg. | 80 mm. Hg. |
| May 24, 1944 | .....a.m. | 120 mm. Hg. | 80 mm. Hg. |
| | p.m. | 132 mm. Hg. | 80 mm. Hg. |
| June 10, 1944, on discharge from the hospital | ..... | 156 mm. Hg. | 82 mm. Hg. |

## COMMENT

We should be on the alert to recognize this syndrome, especially when meningococcus infections are prevalent in the community. The explosive onset, with high fever, the cyanosis, the purpuric or petechial rash, the symptoms of shock with low or falling blood pressure, are the most important diagnostic criteria.

## CONCLUSIONS

We have reported here four cases of fulminating meningococcus septicemia without meningitis, unfortunately known as the Waterhouse-Friderichsen Syndrome. The diagnosis of the condition is essentially a pathological one. The two cases which came to autopsy showed the typical pathological features. The two cases that survived were in our opinion definite cases of this syndrome, as they had typical symptomatology, positive blood cultures for meningococci in the blood stream without evidence of meningitis, and petechial phenomena. They responded promptly to specific treatment, i. e., adrenal cortex extract and sulfa drugs. However, in spite of all this, we cannot be absolutely certain that adrenal hemorrhage was present in the cases that recovered. Martland believes that cases with massive adrenal hemorrhage never recover in spite of any treatment.

Nevertheless, it is important to be on the alert for this syndrome, for unless these cases get prompt and energetic treatment, they will die.

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# VENEREAL DISEASES AMONG THE MIGRANT FARM LABORERS OF NEW JERSEY

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Each year thousands of Negroes migrate from the Southern States to harvest the crops in the Northern Atlantic Seaboard States. During the war to supplement these the War Food Administration has imported large numbers of workers from the West Indies. Both groups have high venereal disease rates but since medical care of the latter group and of all migrants in the vicinity of their camps is the responsibility of the War Food Administration this report will deal only with the migrant workers of Monmouth, Mercer and Middlesex Counties, for whose medical care the War Food Administration is not responsible.

This Department has dealt directly with the venereal disease problem among these workers for several years. At first, examining teams went to the farms to collect blood specimens, and positive cases were sent to our regular clinics for treatment. This plan proved to be cumbersome and unsatisfactory. Workers come and go constantly during the harvest season, and it was impossible to reach them all in this way.

Therefore the travelling teams were replaced by stationary seasonal clinics operated by this Bureau. Farmers were urged to send or transport their workers to these clinics. Each worker was provided with a card indicating that he had reported to the clinic, and the farmers were urged to require their workers to have these cards. Although coöperation has improved over former years, we have never succeeded in examining more than about one-fourth of the migrant workers in the area. Furthermore, the success of the work has been greatly handicapped by the short duration of the season during which treatment can be given in our clinics, the difficulties of follow-up as the workers move from farm to farm, and the difficulty of referral to treatment sources in the South for continuation of treatment.

This year (1944) we decided to intensify our efforts to obtain the coöperation of farmers and also we decided to focus our examinations on finding infectious cases which could be treated with penicillin, thus completing treatment on these cases before their return to the South.

A series of meetings was held with representative farmers and county farm agents. The nature and infectiousness of the venereal diseases was explained to them, and the high rates among these workers in previous years was pointed out in order to impress them with the magnitude of the problem. Literature was distributed, circular letters were sent to all farmers in the area, spot announcements were made on local radio stations, and the Farm Extension Service also sent a circular letter and had their agents promote the project in all ways at their disposal. The State Police and local health agencies also coöperated in the project.

In spite of the intensity of this effort we failed to obtain the complete coöperation of the farmers. Some of them coöperated very well and even provided trucks to transport the workers to our clinics. Many others—perhaps a majority—continued to be apathetic. As a result, only 756 were examined. The exact number of migrant workers who were in the area is not known, but it is estimated at about 2800.

From each migrant worker who reported to a clinic, a blood specimen was collected and each was examined for gonorrhea and for lesions of venereal diseases. Suspicious lesions were examined by darkfield. Routine gonococcus cultures were performed on the women. The positive cultures were confirmed by sugar fermentations. All patients with primary and secondary syphilis and gonorrhea were treated with penicillin.

* Surgeon, U. S. Public Health Service.

The results of these examinations on the first 727 examined are given in Table I (All Cases), Table II (Men), and Table III (Women). Table I shows that, of the persons examined, 40.7 per cent had positive blood tests, 2.2 per cent had lesions of primary or secondary syphilis, and 12.7 per cent were found to have gonorrhea. Some cases of chancroid and lymphogranuloma venereum also were found but are not included in the tables.

The rates of primary and secondary syphilis and of gonorrhea are impressive, especially in the women of age 15 to 24 (primary and secondary syphilis, 6.3 per cent, and gonorrhea, 30.6 per cent). Of course, it may well be true that some of these patients came to the clinic because of their symptoms, and therefore it would not be proper to consider these rates as representing the true situation among the migrant workers as a whole. If we assume that there were 2800 migrant workers in the area with the same sex and age distribution as in those examined, and use these figures as denominators in determining the rates, we find the situation presented in Table IV. The true prevalence rates must lie somewhere between these minimum theoretical rates and the rates in those examined.

## CONCLUSIONS

Most of these examinations were performed shortly after the arrival of the workers in New Jersey. Their medical histories indicated that most of the infections found were acquired in the South and "imported" to New Jersey. How much disease was spread to others on the way North is impossible to estimate. For the transmission of their infections in New Jersey the conditions are very favorable. In spite of some recent improvements, the housing and hygienic conditions of many of these workers are still poor, and sexual promiscuity appears to be frequent. It would be futile to attempt to reduce the amount of sexual promiscuity among these people without first improving their general living conditions. Meanwhile, therefore, we must assume that workers with infectious venereal diseases will transmit their infections freely, and that the only way to control the rates among them and to decrease the hazard to the residents of the area is by finding the cases and quickly rendering them noninfectious by rapid treatment methods.

In view of this fact it is our conclusion that all migrant farm workers—at least those from the South—should be examined for venereal diseases as soon as possible after entry into New Jersey. We believe that it would be very helpful to have a State law requiring this and requiring employers to coöperate and assist.

We have also given some thought to the applicability, in such a situation, of the Interstate Quarantine Law forbidding the interstate travel of persons with infectious venereal diseases. Of course, we concur in the conclusion that this law is generally unenforceable and that the best way to control interstate spread of disease is by providing facilities to decrease its prevalence within the various States. Until this has been accomplished in the Southern States, however, we suggest that it would be desirable to examine migrant farm workers before they leave the South and allow interstate travel of infected persons only after noninfectiousness has been attained, and after the State Health Department concerned has been notified of the worker's destination. To what extent this is administratively possible we are not in a position to know, but we believe that the question should be carefully explored.

## SUMMARY

1. Of about 2800 migrant farm workers in the potato-growing section of New Jersey 756 were examined for venereal diseases. The examinations included blood tests and inspection for lesions and for gonorrhea. The women received routine gonococcus cultures.

2. The venereal disease rate was found to be very high, especially in women 15 to 24 years of age. In the latter group 6.3 per cent of those examined were found to have dark-field positive lesions of early syphilis, and 30.6 per cent were found to have gonorrhea.

3. Most of these infections were "imported" to New Jersey. The hazard to the areas through which these people travel and to the people of New Jersey is pointed out.

4. The living conditions of these workers

are favorable to the spread of the diseases. These conditions urgently need correction.

5. Routine medical examination of *all* migrant workers and prompt application of rapid treatment methods are needed. Legislation to require such examinations and perhaps enforcement of the Interstate Quarantine Law would be helpful.

TABLE I

RESULTS OF VENEREAL DISEASE EXAMINATIONS

BOTH SEXES

| AGE | NUMBER EXAMINED | POSITIVE AND DOUBTFUL BLOOD TESTS | | DARKFIELD POSITIVE LESIONS | | GONORRHEA | |
|---|---|---|---|---|---|---|---|
| | | No. | Per Cent | No. | Per Cent | No. | Per Cent |
| 0- 9 | 6 | | | | | | |
| 10-14 | 47 | 12 | 25.5 | 1 | 2.1 | 3 | 6.4 |
| 15-19 | 123 | 26 | 21.1 | 4 | 3.3 | 23 | 18.7 |
| 20-24 | 129 | 63 | 48.8 | 8 | 6.2 | 33 | 25.6 |
| 25-29 | 97 | 46 | 47.4 | 1 | 1.0 | 12 | 12.4 |
| 30-39 | 154 | 76 | 49.4 | 1 | .6 | 17 | 11.0 |
| 40-49 | 99 | 52 | 52.5 | | | 1 | 1.0 |
| 50 and older | 38 | 13 | 34.2 | | | 2 | 5.3 |
| Not stated | 34 | 8 | 23.5 | 1 | 2.9 | 1 | 2.9 |
| 15-24 Sub-total | 252 | 89 | 35.3 | 12 | 4.8 | 56 | 22.2 |
| TOTAL | 727 | 296 | 40.7 | 16 | 2.2 | 92 | 12.7 |

TABLE II

RESULTS OF VENEREAL DISEASE EXAMINATIONS

MALE

| AGE | NUMBER EXAMINED | POSITIVE AND DOUBTFUL BLOOD TESTS | | DARKFIELD POSITIVE LESIONS | | GONORRHEA | |
|---|---|---|---|---|---|---|---|
| | | No. | Per Cent | No. | Per Cent | No. | Per Cent |
| 0- 9 | 5 | | | | | | |
| 10-14 | 20 | 3 | 15.0 | | | 1 | 5.0 |
| 15-19 | 71 | 8 | 11.3 | | | 10 | 14.1 |
| 20-24 | 69 | 32 | 46.4 | 5 | 7.2 | 12 | 17.4 |
| 25-29 | 54 | 28 | 51.9 | 1 | 1.9 | 7 | 13.0 |
| 30-39 | 100 | 43 | 43.0 | 1 | 1.0 | 10 | 10.0 |
| 40-49 | 68 | 34 | 50.0 | | | 1 | 1.5 |
| 50 and older | 33 | 12 | 36.4 | | | 1 | 3.0 |
| Not stated | 23 | 4 | 17.4 | | | 1 | 4.3 |
| 15-24 Sub-total | 140 | 40 | 28.6 | 5 | 3.6 | 22 | 15.7 |
| TOTAL | 443 | 164 | 37.0 | 7 | 1.6 | 43 | 9.7 |

TABLE III

RESULTS OF VENEREAL DISEASE EXAMINATIONS

FEMALE

| AGE | NUMBER EXAMINED | POSITIVE AND DOUBTFUL BLOOD TESTS | | DARKFIELD POSITIVE LESIONS | | GONORRHEA | |
|---|---|---|---|---|---|---|---|
| | | No. | Per Cent | No. | Per Cent | No. | Per Cent |
| 0- 9 | 1 | | | | | | |
| 10-14 | 27 | 9 | 33.3 | 1 | 3.7 | 2 | 7.4 |
| 15-19 | 52 | 18 | 34.6 | 4 | 7.7 | 13 | 25.0 |
| 20-24 | 60 | 31 | 51.7 | 3 | 5.0 | 21 | 35.0 |
| 25-29 | 43 | 18 | 41.9 | | | 5 | 11.6 |
| 30-39 | 54 | 33 | 61.1 | | | 7 | 13.0 |
| 40-49 | 31 | 18 | 58.1 | | | | |
| 50 and older | 5 | 1 | 20.0 | | | 1 | 20.0 |
| Not stated | 11 | 4 | 36.4 | 1 | 9.1 | | |
| 15-24 Sub-total | 112 | 49 | 43.8 | 7 | 6.3 | 34 | 30.4 |
| TOTAL | 284 | 132 | 46.5 | 9 | 3.2 | 49 | 17.3 |

TABLE IV

MINIMUM PREVALENCE (THEORETICAL) OF VENEREAL DISEASES ESTIMATING 2800 MIGRANT WORKERS IN THE AREA and ASSUMING SAME SEX AND AGE DISTRIBUTION AS THOSE EXAMINED

| Sex | Age | Theoretical Number of Persons | Positive and Doubtful Blood Tests | | Darkfield Positive Lesions | | Gonorrhea | |
|---|---|---|---|---|---|---|---|---|
| | | | No. | Per Cent | No. | Per Cent | No. | Per Cent |
| | All Ages | 1706 | 164 | 9.6 | 7 | .4 | 43 | 2.5 |
| Males | 15-24 | 539 | 40 | 7.4 | 5 | .9 | 22 | 4.1 |
| | All Ages | 1094 | 132 | 12.1 | 9 | .8 | 49 | 4.5 |
| Females | 15-24 | 431 | 49 | 11.4 | 7 | 1.6 | 34 | 7.9 |
| | All Ages | 2800 | 296 | 10.6 | 16 | .6 | 92 | 3.3 |
| Total | 15-24 | 970 | 89 | 9.2 | 12 | 1.2 | 56 | 5.8 |

## 70TH ANNUAL MEETING OF THE NEW JERSEY HEALTH AND SANITARY ASSOCIATION

### January 18, 1945, Essex House, Newark, N. J.

**Theme of the Meeting—MEDICAL CARE: STATUS AND TRENDS**

**MORNING SESSION**

NEED FOR MEDICAL CARE

Reginald Atwater, M.D., Secretary, American Public Health Association, New York, New York

THE IMPACT OF MEDICAL CARE ON PUBLIC HEALTH

E. S. Rogers, M.D., New York State Department of Health, Albany, New York

THE HEALTH INSURANCE PLAN AS DEVELOPED FOR NEW YORK CITY

Winslow Carlton, Director, New York City Insurance Plan, New York, New York

SUMMATION AND DISCUSSION FROM THE POINT OF VIEW OF THE MEDICAL SOCIETY OF NEW JERSEY

Norman M. Scott, M.D., Medical Director, Medical Service Administration, Newark, New Jersey

**LUNCHEON SESSION**

HOSPITAL CARE FOR THE INDIGENT AND MEDICALLY INDIGENT IN NEW JERSEY

Emil Frankel, Ph.D., New Jersey State Department of Institutions and Agencies, Trenton, New Jersey

THE HOSPITAL SERVICE PLAN OF NEW JERSEY

J. Albert Durgom, Executive Director, Hospital Service Plan of New Jersey

CARE OF THE CHRONICALLY ILL

Albert R. Post, Deputy Director, Division of Commerce and Municipal Aid, State Department of Economic Development, Trenton, New Jersey

THE SOLUTION OF THE PROBLEM OF THE INDIGENT CHRONICALLY ILL IN BERGEN COUNTY

Samuel Alexander, M.D., President-Elect, The Medical Society of New Jersey, Park Ridge, New Jersey

# REDUCTION IN TOTAL SKIN FLORA BY THE DAILY USE OF A SOAP CONTAINING DIHYDROXY HEXACHLORO DIPHENYL METHANE

H. J. UDINSKY, M.D., Passaic, N. J.

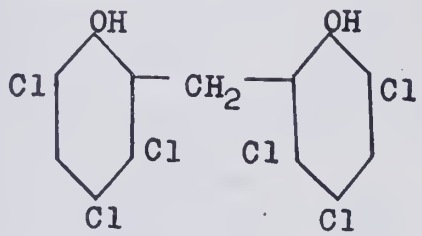
Soap is ordinarily used as a cleansing agent on the human body. This cleansing action is accomplished in the course of washing by the emulsifying effect of the soap and by the mechanical rubbing of the soap lather against the skin. It would, evidently, be advantageous to have the washing process act as a dirt remover and a germ destroyer at the same time. A soap performing both of these functions could be classified as a "Germicidal soap".

The incorporation of a germicidal chemical into a soap does not always produce a germicidal soap, nor one suitable for daily use. Salts of the heavy metals, such as mercuric iodide, when incorporated in a soap produce a drying effect on the skin which makes the soap unsuitable for routine use. The germicidal action of phenolic substances is almost entirely neutralized by the presence of large amounts of soap. The combination to be looked for is a germicide, whose activity is retained to a substantial degree when added to soap and which will leave the soap mild enough to be practical for daily use.

In recent years there have been published many reports of investigations made on the microörganisms found on the human skin, and the action of various germicides on these organisms. Price,[1] in his classic studies of the microbal flora of the skin, has classified these organisms into "transient" and "resident". The presence of the transient flora is accounted for by surface contact and is readily taken off by washing with soap and water. The resident flora is found on the human skin irrespective of contact contamination and is not easily removed by ordinary washing.

In order to determine the degerming effect on the human skin produced by the application of a chemical agent, including a soap, one may apply the procedure originated by Price. In these studies Price has noted that successive washings of a given area of the skin, using approximately the same pressure each time, will result in a progressive reduction of the skin flora at a constantly diminishing rate. By plotting the bacterial counts obtained from these successive washings he obtains a logarithmic curve which tends to level off without reaching zero. Price has found that a deviation in the reduction rate may be produced by extraneous factors such as the use of a germicide in the course of the washings. He further stated that it is thereby possible to evaluate the activity of a degerming agent, whether a chemical compound or a soap, by introducing the particular agent in the course of the washings and noting the resulting deviation from the normal curve.

During the summer of 1941 the writer became interested in a new germicide in the nature of a chlorinated phenol to be described chemically as 2,2'-dihydroxy-3,5,6-3',5',6'-hexachloro diphenyl methane designated by the manufacturer as "Compound G-11" and subsequently referred to as such in this paper. The structural formula is




This chemical compound is a white crystalline substance melting at 164-165° C. It is insoluble in water, but is soluble in alcohol, acetone and dilute alkalies. A soap containing 2% G-11 has been prepared commercially. A 5% solution of this soap which solution does contain 1:1000 G-11 will kill Staphylococcus aureus in 5 minutes at 37° C. when tested in accordance with the standard F.D.A. germicidal procedure.

1. Price, P. B.: J. Am. M. Assn., 1938, 111:1993. J. Infect. Dis., 1938, 63, 301.

Starting August 1941, for over two years this soap has been in daily use under my supervision by a large number of individuals none of whom showed any untoward reaction. In addition, a group of over 200 individuals were patch tested with an 8% solution of a standard bar soap containing 2% G-11. The same type of soap without the G-11 was used as control. Positive reaction of the same nature developed in about 4% of individuals for both the G-11 soap and the control. There were no reactions attributable to the presence of G-11 in the soap.

## EXPERIMENTAL

An investigation was undertaken to determine the effect of the routine use of this G-11 soap [2] on the skin flora by the application of a simplified swabbing technique in place of the more elaborate washing method mentioned above and recently applied in a series of studies of the G-11 soap carried out by Traub et al.[3] This procedure consisted in the examination of swabbing from the dorsal area of each hand. The hands of the writer were used for this purpose.

The tests were carried out under the following conditions:

1. No attempt was made to limit the type of work done by the test subject during the period covering the experiments.
2. No special number of hand washings were made other than those normally required in the course of work.
3. No hand washing was done for about two hours prior to the swabbing.
4. Three successive swabs were taken from the dorsum of each hand. In each case a sterile swab was used, moistened with sterile distilled water and applying approximately the same pressure and covering the same area each time.
5. Each swab was immediately transferred to 10 cc. of standard beef extract agar, rotated thoroughly to disperse the organisms and plated. The plates were incubated for 48 hours at 37° C.
6. No attempt was made to determine the type of organisms present.
7. The number of colonies on each plate were counted. These represent the relative skin flora at the time of testing. The first swabbings were naturally always higher than the second and third, representing immediate contact contamination and were omitted in our calculations. There is no appreciable difference between the readings of the right and left hands. The average of the second and the third reading were taken to represent the skin carrier rate at the time of testing.

These tests were carried on continuously over a period of approximately eleven months. This time was divided into eight intervals in which plain soap was used alternating with seven periods in which G-11 soap was used. During each period five to six individual swabbing tests were made at forty-eight-hour intervals, making a total of eighty tests. The average carrier rate for each period was obtained by adding the counts of the second and third swabbings for the entire period and dividing the total by the number of swabbings made. The resulting numbers are tabulated below and plotted as shown in the accompanying chart.

AVERAGE BACTERIAL COUNT FOR COMBINED SECOND AND THIRD SWABBINGS

| Period Number | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Plain soap used | 1250 | | 1200 | | 2450 | | 2500 | | 2000 | | 2475 | | 1400 | | 1650 |
| G-11 soap used | | 40 | | 21 | | 50 | | 61 | | 45 | | 62 | | 24 | |

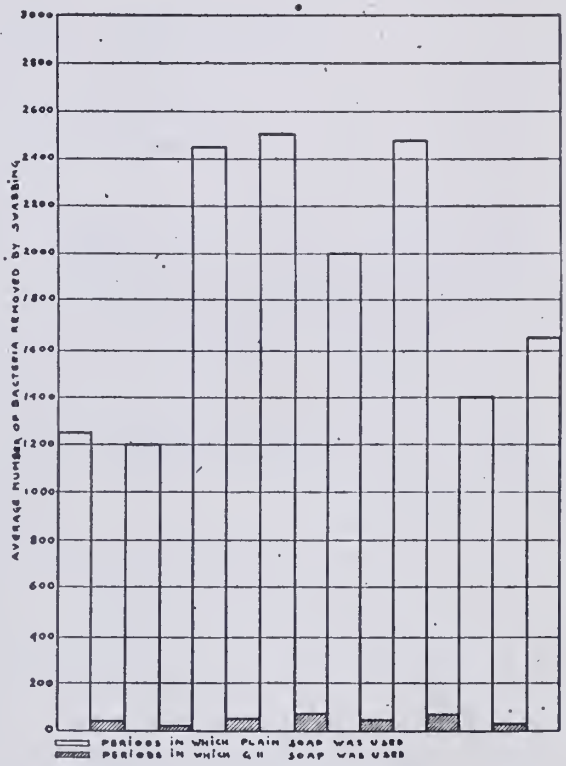
2. The material for these studies was supplied by Givaudan-Delawanna, Inc., New York, N. Y.

3. E. F. Traub, C. A. Newhall and J. R. Fuller: Surg., Gny. & Obst., 1944, 79:205-216.

## SUMMARY AND CONCLUSIONS

These data show definitely the positive action of G-11 soap in maintaining a low total skin flora during and for a period after its regular daily use. The results obtained by the simple swabbing technique are similar to those shown by Traub, who used the more elaborate Price washing method.

It has been demonstrated by E. H. Martin [4] in "Studies on the Relation of Pyogenic Skin Infections to the Skin-Carrier Rate", that the presence of a localized skin lesion produces a widespread increase in microbal skin flora. It may, therefore, be suggested that the G-11 soap would be of benefit in the management of pyogenic skin condition such as impetigo, folliculitis, acne, etc. For the same reason this soap should also be of value in the prophylaxis of impetigo neonatorum and in occupations where cleanliness and low bacterial flora of the skin are desirable, such as in those of physicians, dentists, nurses and food handlers.




## CONTINUOUS CAUDAL ANESTHESIA IN OBSTETRICS

A new method for continuous or fractional caudal anesthesia has been developed by Edwards and Hingson (Am. J. Surg., 57:459, Sept., 1942). It appears to be remarkably effective and yet retains the complete coöperation of the patient. There has been uniform absence of delirium, narcosis, cyanosis, nausea, vomiting, and anoxemia, and no interference with uterine contractions. Every infant in the authors' series breathed spontaneously except one stillborn known to have been lead several days before delivery.

The technic consists in the injection of an initial dose of 30 cc. of 1.5 per cent solution of "Metycaine" (Gamma-[2-methyl-piperidino]-propyl Benzoate Hydrochloride, Lilly) followed at 30 or 40-minute intervals with 20 cc. of the 1.5 per cent solution. In every case there has been complete freedom of pain and discomfort of active labor within five minutes following the initial dose. Episiotomy and outlet forceps, and repair of the episiotomy has been without pain. The average duration of anesthesia has ranged from four and three-quarters to thirteen hours.

One patient described was having eclamptic convulsions when admitted, with blood pressure 220/110. After the initial dose of "Metycaine" was given, the pressure declined to 140/90 and the clinical picture improved remarkably. The anesthetic was continued throughout the day without the blood pressure exceeding 150. She delivered a healthy baby spontaneously thirteen hours after the initial dose.

4. E. H. Martin: Brit. Med. J., August 29, 1942, p. 245.

# PSYCHIATRY IN THE POST WAR ERA *

By Joseph G. Sutton, M.D.
Essex County Hospital, Cedar Grove, N. J.

We use the term "era" as a fixed point of time from which a series of years is reckoned. It is, therefore, appropriate that we speak of the Post-War Era, for the cessation of World War II will indeed be a milestone in the march of time, and the years immediately following will be noteworthy for either good or evil, opportunity seized or lost. This holds in the several fields of endeavor, and in none more than in our specialty.

We have read and heard much about post-war problems and post-war planning with reference to the returning soldier, until some have come to confuse the soldier with his problem. A chief-of-police told me recently that he didn't know what he was going to do with the returning soldier. He opined that the average age of his force is well over 45, and, said he, "Those young Indians will come back here knowing jujutsu and all the other tricks of the trade." A happier outlook, however, was recently voiced by Mr. Homer B. Clarke, president of the National Association of Bank Examiners. Said Mr. Clarke, "If we choose to look at our millions of returning soldiers as a problem, we may be sure that we will have a problem. I prefer to view them as a marvelous opportunity. Given half the support in peace time that they now receive, they will help make our country much better and stronger."

Likewise in the field of mental health confusion could easily be that the soldier's problems are separate and distinct and different in kind from those of the civilian. They are distinct, but only because of the unpayable debt that we owe the soldier. In kind, his problems are identical with the civilian's: his the same goals, his the same obstacles to their realization, his the same symptom complex. Kardiner,[1] an outstanding authority on the neuroses and psychoses of war, says that no psychiatric symptom complex is observed in war which does not occur in peace. He adds, "The only influence that war has is that it offers opportunities for the development of neuroses in much greater concentration and frequency than do the conditions of peace." The late Dr. Salmon[2] claimed that war neuroses, like those of civil life, are an elaboration of one central theme, escape from an intolerable situation in real life to one made tolerable by the neuroses. Dr. Karl Bowman[3] says that war neuroses offer no new problems, the general theories of etiology, prognosis and treatment being equally applicable in war and peace. And again Dr. Michaels[4] says that the neuroses of civilian and soldier, and the soldier in preliminary training and in actual warfare, are fundamentally identical in type.

Now what was our mental health when the war started? Individually and in the aggregate, it may be said to have been at an astoundingly low ebb. We have no figures for the general population, but the military gives us some very revealing data, namely, that 13 per cent of the rejections at the induction centers and 45 per cent of army medical discharges are for neuro-psychiatric causes. Taking Dr. Rennie's statement that only 20 per cent of the N-P discharges are service connected, in other words that 80 per cent of the dischargees' disorders antedated induction, we see that the 13 per cent figure at the induction centers is appreciably elevated. So much for the individual.

Now as for our aggregate mental health: One might cite as some index the sudden mass hysteria following the broadcast of a bit of impossible fiction of a Martian invasion. That

* Presented at the Fall Meeting of the N. J. Neuro-Psychiatric Association on November 15, 1944.

1. Kardiner, A.: "The Neuroses of War." War Med., 1:219, March, 1941.
2. Salmon, T. W.: "Care and Treatment of Mental Diseases and War Neuroses." New York, War Work Committee of the National Committee for Men. Hyg., 1917.
3. Bowlman, Karl M.: "War Neuroses." N. Y. S. J. Med., 42-1729, 1942.
4. Michaels, J. J.: "The Medical Department of the U. S. Army in the World War." War Med., 2-175, 1942.

is an isolated instance and unique in our experience, of course, but it shows the frame of mind of our people en masse. Better still, consider how in our country race is arrayed against race, class against class. We speak of this as intolerance, but in reality it is paranoia. Intolerance is spawned by ignorance. We are living in a relatively enlightened age, we know our neighbor better than we ever did before. We should be more neighborly. We are not, and why not? The answer is "Fear". It is not that we think that our neighbor has not the capacity to attain our status. *We are afraid that he has.* If he should, then we would lose our sense of superiority. In short, we feel insecure, we are afraid, we are paranoid.

Actual and potential schisms in our national life are ever present. Certainly class struggles are not new. At this time, however, I think, considering the mass hysteria—notably the Ku Klux Klan—following the last war, we as psychiatrists may well ponder the general subject. Our science is sufficiently advanced that we can distinguish between real, pretended and unconscious motives. We know the power of suggestion, when a class or group feels its security is threatened, and we know that, once aroused, the warlike spirit is not easily bridled. May not the field be just as fertile now as it was then for mass hysteria, or paranoia, if you will?

What of the war's impact on our mental health? Let us reflect that we entered this war in a different frame of mind from that we had in 1917. Then we were on a crusade. Then we were fighting to make the world safe for democracy, fighting a war to end all wars. Recalling the fiasco at the peace table, the intervening period of pacificism—remember how the college lads pledged themselves that they would refuse to bear arms in case of another war?—, disarmament movements and the like, we entered this war disillusioned, with a feeling of futility. Too, after a decade of the greatest depression in history, we were in a measure tired and discouraged. As one writer so well expresed it, intellectually we knew the war had to be won, but emotionally we were confused and split. In other words, our emotional tone was not in keeping with content of thought. In an individual with such symptoms, you and I know the diagnosis.

Consider the suddenness with which we were catapulted into the struggle. Even our Government was stunned by it. The more discerning may have seen that we were at war with the repeal of the Arms Embargo Act; Mr. Average Citizen thought of war as probable, but somehow in the remote future. Reserves were called not after days, but within hours. In a jiffy our routine was broken—a catastrophe for man or beast. Home circles and other ego-supporting ties were broken. Careers were interrupted. Regimentation was the lot of the soldier, and to a lesser degree of the civilian. These counted, but worst of all was the emotional struggle: The individual aversion to war vs. the collective effort to wage war; the selfish individual inclination to evade responsibility vs. the individual sense of honor and duty.

Added to the chaos in our total war effort were the great migrations of our workers, taking them from their accustomed milieu; living conditions were crowded and unwholesome; mothers went into industry; all further disrupting the family circle and increasing the emotional strain, and as a concomitant contributing to a mounting juvenile delinquency. Another emotional factor yet to be evaluated, and not without serious implications in its effect on the boy and the family circle, is the taking into the armed forces of the teen-age boy by the hundreds of thousands. Conceivably this enforced early maturation may be a boon to the one; it may be a tragedy to the other.

And yet to come are the readjustments after the war. We naturally think first of the returning soldier. A benevolent government is thinking in terms of jobs and monetary compensation. Very important indeed, but we psychiatrists know that that is only one aspect of his readjustment and that even it is not without its hazards; i. e., lavishness may be just as unkind to the soldier as niggardliness. We know, too, that the soldier's readjustment is inseparably linked with that of the civilian,

the family, the community. GI Joe, as we have been well told, will not be the boy who left for the army, and his home will not be the home that he left. The one has built up unreal images of the other—most likely in the nature of unreal virtues and halos—in their separation. Both will have to be realistic, the one accepting the other as the other is.

In the post-war period economic readjustment will occasion stress and strain to all our people. The workers who migrated by the tens of thousands will have to retrace their steps, or seek new locations. Even if wartime wage scales are maintained, unemployment or interruptions of employment will greatly reduce per capita income. Most tragic of all, of course, will be the lot of the less fit worker. As in the past he will be the first to go, when industry is forced to retrench, and he is least able to withstand disintegration of mental and moral fibre.

I have pointed out some factors, suggested others, that may have serious implications in our effort for maintenance or attainment of mental health. I have perhaps tarried too long, but that only because I believe a clear understanding of our problem is the best cue to its solution.

What are we going to do about it? There is no one front, no one panacea. The problem is complex. Mental illness is not as simple as physical illness, because the whole personality is involved, together with the environment in which it is trying to adjust. We are the product of our time. We are also the creators of our environment.

Whatever our attack, we yet have to be governed by one fundamental, so well established that it is axiomatic, namely, that we can understand human behavior only with reference to a set of needs which each individual is attempting to satisfy through his own peculiar and individual way.[5] Let us review the three basic categories of personality needs:

1. Physiological — These are essentially needs to function—nutritive, eliminative, sex, activity, rest.

2. Social—These are essentially needs for status—a sense of belonging and being like others; security in the family circle, play groups, etc. Here persons with oddities in appearance, gifts, manners, social and cultural backgrounds, have serious problems.

3. Ego or Integrative—These are essentially needs to assimilate experience and achieve belief in self-contact with real life situations, harmony with reality, fair balance between success and failure in order to achieve a sense of one's own personal adequacy to meet life, increasing freedom to direct one's own behavior as knowledge and wisdom grow.

These are the basic categories of personality needs. Briefly, the individual's goals are: (1) Understanding of self—learning to live with and accept one's self. (2) Understanding of others—learning to live with and accept others. (3) Some mastery of skills that are personally satisfying and socially useful (play and leisure, work and occupation). Satisfaction in tasks which foster a sense of personal worth and adequacy.

Our task then is to assist our people in attaining these goals, individually and en masse. To the extent that we can and the circumstances demand, our work will be individual. We shall study and interpret the individual's peculiar strivings, personality lacks and environmental goal obstructions. This is but orthodox psychiatry, established by experience.

However, our overall problem is not as simple as that. The figures I have quoted indicate the widespread maladjustment in civilian ranks. Monthly 25-30,000 soldiers are given N-P discharges, 80 per cent not service-connected, according to Dr. Rennie. This 80 per cent will also be a civilian responsibility. Manifestly the individual approach will be quite inadequate, and, therefore, ineffective. Our work will be with the masses; its scope national.

The answer would seem to be a national mental health program, embracing prevention and therapy; one beginning at the cradle, ending at the grave. In passing, may I observe that we have been remiss in mental hygiene work with the aged, a matter of considerable

5. Ingebritsen, O. C., Ph.D.: Montclair State College

import in view of the rapid increase in our population of 65 and over.

It is not within the scope of this paper to discuss the ways and means of implementing such a program. My plea is that we as psychiatrists enlist in this great enterprise, each within his own sphere and influence. Dr. Alan Gregg of the Rockefeller Foundation at the Philadelphia meeting of the A. P. A. in May arraigned psychiatrists, because we are too few, too busy and too inarticulate (and too uninformed about medicine). His indictment, we must admit, has considerable validity. We cannot as individuals start out recruiting psychiatrists. We can, however, be simply *not* too busy to make our contribution; *not* too inarticulate to interpret and guide, where our training peculiarly fits us so to do. This, I believe is the rôle of the psychiatrist in the post-war era.

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## WITH NEW JERSEY MEDICAL AUTHORS

Compiled by MILDRED V. NAYLOR, Librarian, Academy of Medicine of Northern New Jersey

It is requested that any New Jersey physician who publishes an article outside the state, notify the Editorial Office in Trenton, giving the title of the paper and the name of the periodical, as well as the month, date, volume and page number. It would also be helpful to this office if members would notify us of articles published by their colleagues.

CRASTER, CHARLES V.—Newark
New payment plan for the care of the indigent sick. J. Med. Soc. New Jersey 41: 437-439, Dec. 1944

EBNER, PAUL G. (in service)—Camden
Use of continuous spinal anaesthesia for analgesia in labor and during delivery. A preliminary report. J. South Carolina Med. Assoc. XL: 224-227, Nov. 1944

EPSTEIN, JEANNE A.—see Lee, S. W.

FOLEY, E. J.—see Lee, S. W.

FORD, RALPH A.—Belleville, and ROBERT B. MARIN—Montclair and New York
Hemorrhagic chicken-pox—case report. J. Med. Soc. New Jersey 41: 440-441, Dec. 1944

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Arthritis. Yearbook of General Medicine, 1944, pp. 26-29

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KALB, S. WILLIAM—Newark
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Waterhouse-Friderichsen syndrome; report of a case with recovery. J. Med. Soc. New Jersey 41: 400-401, Nov. 1944

KORNFELD, WERNER—East Orange (with Edmund Nobel, London)
Evaluation of nutritional state in children. Lancet 2: 543, Oct. 21, 1944

LEE, S. W.; FOLEY, E. J., and EPSTEIN, JEANNE A.—(Wallace Laboratories) New Brunswick
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Isoimmunization by the Rh factor—a new cause of fetal and neonatal morbidity. Human Fertil. 9: 65-72, Sept. 1944

LOESER, LEWIS H. (in service)—Newark (with Maj. Reynold E. Church)
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MARIN, ROBERT B.—see Ford, Ralph A.

PIZZI, FRANCIS W. (in service)—West Orange (with Frank W. McCarthy)
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# STATE ACTIVITIES

## SYNOPSIS OF SOME OF THE IMPORTANT TROPICAL DISEASES

By Committee on Tropical Diseases, CHRISTIAN P. SEGARD, M.D., Chairman; and JOSEPH R. MORROW, M.D.

TECHNICAL ADVISERS

DR. EDWARD HENDERSON, Bloomfield, N. J., Pathologist
DR. REDGINAL HEWITT, Pearl River, N. Y., Parasitologist
DR. A. P. RICHARDSON, New Brunswick, N. J., Pharmacologist
DR. THURLOW C. NELSON, Rutgers University, New Brunswick, N. J., Zoölogist

Malaria and the dysenteries are the tropical diseases most likely to be found in returning members of the armed forces. The prompt diagnoses of most cases of these diseases should not be difficult in New Jersey where laboratory service is readily available, particularly if physicians are alert to the usual symptoms of these diseases.

The symptoms of some tropical diseases are quite obscure. Several months to a year or more may pass before a definite diagnosis is made. This is because so many tropical parasites require that period of time to reach mature form. Early laboratory aid should be sought. State and National Public Health Departments will, no doubt, set up the necessary consultant service.

A control program will need prompt and complete reporting of cases. If this is done through the regular health reporting channels it will prevent spread through possible vectors. Mosquito extermination in the home is a "must" in most tropical diseases.

While malaria and amebiasis have a world-wide distribution, most of the other tropical parasitic infections occur in localized areas. If the patient was domiciled in a certain area only, the possibility of the principal disease of that area is of course greatest.

Filariasis is present in the South Pacific, Africa and India.

Leishmaniasis is present in South America, Africa and India.

For the above reason the case history in tropical diseases is of the greatest importance. Where the patient has traveled and been domiciled is of prime consideration in arriving at a diagnosis.

*Malaria:* A blood disease developing at the expense of the red blood cells with fever, cachexia, splenic enlargement, and anemia. The acute form is ushered in with chills and fever. The chronic form is characterized by splenic enlargement, cachexia and anemia. (The parasite, Plasmodium, is transmitted by certain Anopheles mosquitoes.) There is a reduction of neutrophiles and an increase in monocytes in the early stages. When the patient has come from a highly malarious area, symptoms such as vomiting and coma are cause for suspicion.

*Vivax M:* Caused by P. vivax (benign tertian). Within 11 to 14 days after mosquito bite the common symptoms of malaria appear. The life cycle in the R. B. C. is 48 hours, paroxysms on the third day (variable). Enlargement of the red blood cell with Schuffner's dots occasionally present. Gametocytes circular.

*Falciparum M:* Caused by P. falciparum (malignant tertian). Within 11-14 days after infection the symptoms appear. The life cycle in the R. B. C. is 24-48 hours, paroxysms daily, sometimes irregular, occasionally on the third day, may last a day or more. No enlargement of R. B. C. Maurers' dots sometimes present in blood smear. Crescent-shaped gametocyte is characteristic and is usually extracellular. All types of R. B. C. are attacked, therefore more rapid destruction and possibly more rapid division of the asexual forms, hence the name malignant. Few cases of this type relapse. Prompt and adequate therapy is essential.

*Malariae M:* Caused by P. malariae (quartan). The symptoms appear in a somewhat longer time than other types. No enlargement of R. B. C., slow destruction since only more

mature erythrocytes are attacked. This selective penetration is not yet conclusive. Paroxysms variable every fourth day lasting only a few hours are common. Gametocytes circular.

*Ovale M:* Infects humans but at present confined to Africa.

In the detection of the parasites thick smears of blood or bone marrow will probably save time and give the best results if the technician is acquainted with their appearance in thick smears. A thin smear is necessary to determine species. Should be suspected in every ill person returned from the tropics. In relapsing cases, fever as such may not be regular and is not periodic.

Where a case of malaria is noted in New Jersey a report to the local Board of Health is mandatory on the part of the physician.

### TREATMENT OF CLINICAL MALARIA AND MALARIAL PARASITEMIA

a. Clinical malaria (uncomplicated. Patient able to retain oral medication). Atabrine dihydrochloride 0.2 gm. (3 grains) every six hours day and night for 5 doses; followed by 0.1 gm. three times daily after meals for 6 days. Total 2.8 gms.

b. Clinical malaria (complicated by vomiting). Atabrine dihydrochloride 0.2 gm. in 5 cc. sterile distilled water injected intramuscularly into each buttock. If necessary, one or two additional doses of 0.2 gm. may be given intramuscularly at intervals of six to eight hours. As soon as patient can retain oral medication atabrine should be given by mouth in such dosage as to give a total of both routes together of 1.3 gms. in 48 hours followed by 0.1 gm. three times a day after meals for five days (total 2.8 gms. in 7 days). Maximum blood concentration of the drug is obtained about one hour after the intramuscular injection.

c. Malaria complicated by coma or pending coma. Quinine dihydrochloride 0.6 gm. in 300-400 cc. of sterile physiological saline injected very slowly intravenously. Repeat in 6-8 hours if required, but it will be better to anticipate the need by giving atabrine intramuscularly following the initial intravenous quinine. As soon as the patient can retain oral medication the complete course of atabrine should be given. Quinine alone is recommended only in those rare cases who are intolerant to atabrine. Then give quinine 1 gram by mouth three times daily for two days and continue with 0.6 gm. three times daily for seven days.

The use of plasmochin alone is not recommended since the margin of safety between the effective and lethal dose is too narrow to warrant its use.

NOTE: Quinine sulfate tablets are more quickly effective if dissolved before being taken. Ten grains of quinine sulfate may be dissolved in 1 ounce of water which has been acidified by the addition of 10 minims of diluted sulfuric or hydrochloric acid (U. S. P.) or 2 Gm. (30 grains) of citric acid.

Black Water Fever occurs only in falciparum M. The cells hemolyze and may block the kidneys causing fatal anuria. Some believe that Black Water Fever is due to quinine or improperly treated malaria. It is apt to follow incomplete quininization of long standing aestivo-autumnal malaria.

Patient should be warned against chilling and overindulgence in alcohol.

Totoquine has an action which closely parallels that of quinine. It can only be given by mouth.

*Kala Azar,* Dum Dum Fever: (Black Fever, because of darkened skin spots.) Febrile Tropical Splenomegaly—Visceral leishmaniasis. Caused by a protozoal parasite, supposedly transmitted by the sand fly (Phlebotomus). There is also a cutaneous (Oriental sore) and muco-cutaneous leishmaniasis.

This disease persists for months or years with dysenteric complications. Typical of Kala Azar is the threefold picture: double daily rise in temperature, a leucopenia and the enlarged spleen (a liver enlargement follows). The disease is confirmed by the finding of Leishman-Donovan bodies from splenic puncture, sternal puncture, or blood smear. (Not to be confused with Donovan bodies associated with lymphogranuloma inguinale.) With a normal or high leucocyte count the odds are against it being Kala Azar. Leucopenia appears within a year of the onset. The leucocytosis in leukemia serves to differentiate the two and thus avoid the splenic puncture in leukemia. The therapeutic test of quinine administration excludes

malaria. Progressive emaciation is typical of advanced cases.

*Treatment:* Tartar Emetic was the first antimony compound used in this disease. A 2 per cent freshly prepared solution intravenously, on alternate days, beginning with 2 cc. of the solution containing 0.04 gm. of the salts. Each succeeding dose increased 1 cc. at each administration up to a maximum of 5 cc. or 0.1 gm. of the salts and continued at this level. The injections should be made on alternate days and continued until 4 gms. of the salts have been administered. The temperature (taken every 3 hours to show the double daily rise) is controlled and the body weight shows improvement in a month or so. Stibamine glucoside, neostam (a pentavalent antimony), anthiomaline (lithium antimony thiomalate), neoantimosan (Fuadin-chemically antimony disulfonate of sodium), have each been used and are probably equally effective. Massive doses of ascorbic acid (vitamin C) have been reported to be of value in the parasiticidal action of antimony.

*Aromatic Diamidines:* These should be reserved for the cases that are antimony resistant. Dosage 1 to 2 mgms. per kilo of body weight.

*Dysentery:* Characterized by frequent watery, bloody, mucous stools with tenesmus, fever and ulcerations. Amoebic and bacillary dysentery are caused by distinct specific organisms. Dysentery, both amoebic and bacillary, are reportable diseases in New Jersey.

*Amoebic D:* The organism endameba histolytica may be found in the loose diarrhoeic stools (seldom in formed stools) and in the destructive ulcerative processes of the lower bowel. Examine stool immediately after passage—especially masses of mucus. There may be an amoebic abscess of liver, lung, or other organs without intestinal symptoms. The diagnosis is made only on the microscopic finding of motile amoeba with ingested red blood cells, by cultural methods and by the complement fixation test.

*Treatment:* Acetarsone or carbarsone. 0.25 gm. is given twice daily after meals for 2 days, then the same dosage three times daily for three days or longer.

Emetine. 0.065 gm. in 1 cc. solution intramuscularly, daily for 6 days then .03 gm. intramuscularly for 6 days. Not to exceed 1.0 gm. in 40 days. 0.6 gm. in 1 cc. solution by mouth 3 times a day for 7 days.

Diodoquin. 0.6 gm. by mouth 3 times daily for 7 days. Some advise 1.5 gm. to 2. gm. daily for 16 to 20 days.

Chinioform. 1.0 gm. three times daily for 7 days.

Vioform. .25 gm. three times daily for 10 days.

*Bacillary D:* A mucous stool with gross blood and the microscopic and cultural findings confirm the diagnosis. Culture methods for Shigella are also useful in diagnosing the specific type of bacteria causing the dysentery.

*Treatment:* Sulfadiazine is the drug of choice with sulfathiazole second. A 2.0 gm. initial dose is followed by 1 gm. every 6 hours until the symptoms subside.

(2) Succinylsulfathiazole and sulfaguanidine are also effective.

*Filariasis:* This is a widespread disease caused by slender, round worms whose larvae require an intermediate host for a part of their life cycle. The adult worms are found in the lymphatic system, subcutaneous tissue and in body cavities. Several species cause different diseases each with a distinct symptom complex.

1. Wuchereria-bancrofti. Transmitted by Culex, Anopheles, and Aedes mosquito. Microfilariae may appear in the blood one to one and a half years after the initial infection. They are most numerous in the peripheral blood after 8 p. m. and increase in numbers up to 2 a. m. Patient may reverse this rhythm as all mosquito vectors are not night feeders. It is the adult worm that causes partial or complete plugging of the lymph channels. (More commonly in the groin and genitalia. This is the chronic stage and leads to the well-known elephantiasis.) The extent of the invasion determines to some extent the severity of the symptoms in the acute stage. A few months to a year after exposure there may appear a retrograde lymphangitis associated with a distal red, tender, painful area lasting one to eight days and accompanied by malaise, fever, headache, and vomiting, with termina-

tion by lysis. These signs and symptoms tend to be recurrent. Obstructive filariasis or elephantiasis is the exception rather than the rule and usually follows years after the original infection. It is usually preceded by recurrent acute attacks. (It is usually the result of repeated infection.)

2. W. malayi. The vectors are Mansonia or Anopheles mosquitoes. The worms are said to have a predilection for the lymph tracts of breasts and arms. Otherwise they are similar to W. bancrofti.

3. Loiasis (Loa Loa-Eye Worm). Transmitted by the Mango fly, relative of the American deer fly. The worm reaches the adult stage in two years after infection through the skin. They sometimes migrate through the tissue of the lower eyelid, hence the name. They may invade the subcutaneous tissue anywhere in the body.

4. Onchocerciasis. Species of biting flies (gnats) are the vectors. Nodules develop slowly in the scalp and skin of the trunk over a period of several years. The nodules should be excised as soon as the diagnosis is made.

*Treatment:* There is no specific treatment for Filariasis. The sulfonamides occasionally give relief (temporary) in the lymphangitis. This relief may be due to the drug action on the bacteria involved in the attack. Both trivalent and pentavalent antimony salts are being investigated as possible therapeutic agents. (See treatment of Kala Azar.) Surgical removal of the worms is quite effective. Filariasis is a reportable disease in the State of New Jersey.

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Several other tropical diseases are listed below. It is felt that at the present time there is little or no possibility of their extension in the United States.

1. Leprosy. While this disease is present in the United States there is little indication that it will be brought back by returning service personnel.

2. Cholera. Vaccination and high sanitary standards have practically eliminated this disease in the service. Vaccination should be repeated every six months during exposure.

3. Schistosomiasis. The species of snails that are the vector of this disease are absent in Continental United States. We do not know whether domestic species of snails will carry this disease. Schistosomia Mansoniae are common in Puerto Rico and Venezuela.

4. Dengue Fever (break bone fever). Caused by a filtrable virus. Transmitted by Aedes mosquitoes. Sudden in onset, resembles yellow fever in some ways, but has a much wider distribution.

5. Yellow Fever. Vaccination has controlled this disease and practically eliminated it in North America. Jungle yellow fever is still endemic in South America.

6. Rickettsial Infections. Typhus, Brill's Disease, Rocky Mt. Spotted Fever and Japanese River Fever (Tsutsugamushi).

7. Tropical Eosinophilia. Usually secondary to a tropical illness. A specific syndrome of cough, asthmatic breathing, loss of weight and an eosinophil count as high as 1800 per cmm. has been reported without an associated infection. Arsenic and carbarsone have successfully treated single cases.

8. Trypanosoma Gambiense. (Sleeping Sickness.) Transmitted by bite of tsetse fly prevalent in Africa.

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Intestinal Amebiasis. Editorial. Lancet I, 793-794 (June 14) 1944.
Filariasis. Public Health Aspects and Prognosis. Ill. Med. J. 86: 96-97 (August) 1944.

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## AMENDMENT TO BY-LAWS

### (To conform to 1944 amendments relative to dates of Official List)

Chapter IX—Section 2-a—On the first day of January in each year there shall be levied on each component society a per capita assessment on the membership of such component society, as hereinafter set forth (Par. b), to be paid to the Treasurer of The Medical Society of New Jersey not less than five days before the *fifteenth of March* (change to *first of March*).

# INTERNATIONAL COLLEGE OF SURGEONS

## Report of Committee to Study Post War Planning

As Read Before the House of Delegates by
Watson B. Morris, M.D., Chairman, Springfield, N. J.

Your Committee has studied the many phases of Medical Practice as it will affect the profession in the Post War Era, and presents for your consideration the following principles and recommendations:

We believe the American system of Medical Practice is by far the best in the world.

We believe it has and, in spite of war conditions, is producing the most satisfactory and unequaled type of Medical Practice to be found under any other plan in any other section of the globe.

We feel that in a Democracy such as ours, this system must be preserved, so that we may continue to render such service.

We reaffirm our faith in the free competitive, individual private practice system, and maintain that it will continue to function, and result in a constantly improved type of medical service in the Post War Era, so we recommend that further steps be taken to maintain the prestige and repute of our present system.

This can be accomplished only by keeping the control of Medical Practice in the hands of the doctors, aided by a closer coöperation and coördination of its professional activities through our own medical organizations and other interested agencies, directly controlled by the medical profession.

We all recognize the desirability of widespread distribution of the benefits of medical science, and its indispensable factors in promoting the health of our people.

We also feel that in order to provide good medical care to all of our people, it is necessary that changes be effected in the economic phases of medical practice.

We recognize, as does the American Medical Association, that the profession at large has always welcomed any constructive change in the method of payment for services rendered, which were sound and which would not result in a deterioration of the service rendered.

Organized Medicine through the parent body, which is the American Medical Association, has for some years, approved the principle of pre-payment plans for medical service, when the plans have been operated under conditions where the existing high type of medical service has been maintained, and where supervision and control of such plans have been approved by the recognized medical profession.

As to the medical care of the truly indigent, we feel that the responsibility for their medical care should be assumed through some cooperative arrangement between Federal, State or Municipal Government and the medical profession.

We agree to the principle of subsidies as an aid to those in need of medical care, but unable to secure it through their own efforts and resources. However, these subsidies should be allotments for specific purposes and distributed by specific agencies, provided the Government control or regimentation of the professional activities of the physician rendering such service be definitely eliminated.

We think it is as much a function of the Government to aid in the prevention of illness and the restoration of health for those of its needy citizens, as it is the duty of the physician to render his best efforts and medical services to achieve this end.

Provisions for the return of our colleagues who are making personal sacrifices to answer the call to war should be studied and planned for. Many, and particularly those having taken the shortcut to graduation in medicine, will have had limited or no hospital training, thus it would seem not only necessary, but imperative, that refresher courses, graduate and postgraduate training be provided for them.

Many of our hospitals do not provide for any interne teaching, while others meet only the minimum requirements. This means that in order to provide the needs for these men, the smaller hospitals should provide for this teaching, either by their own staff, the larger hospitals or when available by the college faculty.

All of this is vitally necessary if we are to maintain our high standards of medical education in the Post War Era.

The system of free and independent medical schools, divorced from political control or domination, must be restored as soon as possible after victory is won. Medical research and scientific advancement must be free to continue its rapid stride, if we are to maintain or surpass that of the past.

Above all else, we must be vigilant and exert our utmost efforts to preserve our democratic system of private practice, so that when our men return they will be able to return and find their rightful place in their respective communities.

## CHANGE OF ADDRESS

The Executive and Editorial Offices have moved to the new home at 315 West State Street, Trenton. The telephone number remains the same—Trenton 5776.

Members are invited to visit the new home and offices any time they are in Trenton.

## THE AMERICAN COLLEGE OF SURGEONS
## NEW JERSEY INITIATES—1944

George D. Appold ..... Bergenfield
George A. Bourgeois ..... Jersey City
Sidney Brooks ..... Paterson
Irving Chrisman ..... Paterson
Roy Ciccone ..... Nutley
Baxter L. Clement ..... Newark
Robert A. Cosgrove ..... Jersey City
Lewis C. Fritts ..... Somerville
Elias J. Hatem ..... Paterson
James H. Hemphill ..... Riverton
William H. Huber ..... Maplewood
Erwin J. Kaderabek ..... East Orange
Eugene M. Kiely ..... Hoboken
William Kruger ..... Newark
Elias D. Lawrence ..... Paterson
Benjamin F. Lee, Jr. ..... Camden
Ervin McElroy ..... Rockaway
Ernest Reeves ..... Passaic
Alexander Strelinger ..... Millburn
Raymond A. Taylor ..... Lakewood
John L. Varriano ..... Jersey City
Ralph S. Wright ..... W. Collingswood

## OBITUARIES

### DR. JOHN H. BROWN

Dr. John H. Brown of Passaic died of a heart attack on November 28, 1944. He had been ill for several years but continued his practice until his death.

Dr. Brown was born in Wilmington, N. C., in 1896. He received his medical degree at the University of Vermont in 1914, and began to practice medicine in Passaic in 1919.

Dr. Brown was a member of the Passaic County Medical Society, The Medical Society of New Jersey and the American Medical Association.

### DR. CHARLES C. CLARK

Dr. Charles C. Clark, Union City, died on November 29, 1944, after a long illness.

Dr. Clark was born in New York in 1869. He was graduated from New York Medical College in 1898 and two years later started his practice.

Dr. Clark, dean of the medical profession in Union City, was a former town physician in West Hoboken. He was a member of the Hudson County Medical Society, The Medical Society of New Jersey and the American Medical Association.

### DR. ALLEN CORSON

Dr. Allen Corson, well-known Ocean City physician, died of a heart attack on December 25, 1944.

Dr. Corson was born in 1881 and was graduated from Princeton University in 1904 and from Hahnemann Medical College three years later. After practicing medicine for two years in Atlantic City he moved to Ocean City.

Dr. Corson was a member of the Cape May County Medical Society, The Medical Society of New Jersey and the American Medical Association.

### DR. LOUISE CORA KRALICK WARNER

Dr. Louise Warner, 44, who until a year ago maintained an office in Hasbrouck Heights, died in Pittsburgh, Pa., on November 24, 1944, of a heart ailment. Her husband, Lieutenant Colonel Norman K. Warner, is in France with the Army Transport Command.

Dr. Warner was graduated from the University of Pittsburgh Medical School in 1930 and gave up her practice in Hasbrouck Heights to be with her husband while he was in this country. She first practiced in Wahjamega, Mich. While in Hasbrouck Heights she practiced under her maiden name.

Dr. Warner was a member of the Bergen County Medical Society, The Medical Society of New Jersey and the American Medical Association.

# COUNTY SOCIETY REPORTS

## ATLANTIC COUNTY

Walter B. Stewart, M.D., Reporter

The regular monthly meeting of the *Atlantic County Medical Society* was held on Friday, October 13, 1944, in the Chelsea Hotel.

DR. HENRY B. DECKER of Camden, Associate Professor of Medicine, Jefferson Medical College, was the speaker of the evening, his subject being "Some Aspects of Common Skin Diseases". He spoke of the skin as an organ whose functions are (1) protection, (2) heat regulation, and (3) tactile sensory. The skin reacts to different irritants in different ways, such as an edema response and a dermatitis response. Most of the discussion was based on a series of illustrative lantern slides of interesting skin conditions, among which were ichthyosis, sunburn, basal cell epithelioma, carcinoma caused by x-ray burns. A large group of dermatoses is caused by chemical irritants, such as poison ivy, the primrose, or even the common carrot; hair dyes and cosmetics are common offenders. Farm sprays or the metal of your watch, drugs such as bromides and arsenic, all may be the causal factor of the dermatitis.

There followed a brief discussion of eczema, erysipelas, impetigo, sycosis vulgaris, and the common fungus infections. In infantile eczema it is well to eliminate orange juice, cereals, eggs and wool as frequent offenders. Lice and scabies sometimes present problems. Certain keratoses are caused by deficiency of vitamin A, and pellagra by lack of nicotinic acid. Lupus erythematosus is seen occasionally.

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The November meeting of the Society was held at the Chelsea Hotel on Friday, the 10th. DR. EDWARD WEISS, Professor of Clinical Medicine at Temple University, discussed the "Psychosomatic Aspects of Cardio-Vascular Disease", by which is meant the inter-relationship of the emotions and the bodily processes, a new term for a study as old as medicine itself. The study of the human body and the use of laboratory instruments of precision have stood in the foreground of our machine age of medicine, while the study of the emotions has remained in the background. Psychosomatic medicine is not a specialty, but rather a point of view. The soma should be studied not less, but the psyche more. This subject has now come of age, being used by Dr. Henry A. Christian in the new 15th edition of "Osler's Principles and Practice of Medicine" as the introductory subject.

Dr. Weiss proceeded to a discussion of the influence of the emotions on the normal and the diseased heart. He brought out the characteristic differences between cardiac pain of organic and of functional origin. In cardiac neurosis the most frequent symptoms are substernal pain, breathlessness, palpitation, often a slight systolic murmur at the apex in an overactive heart, fatigue ("aching tiredness"), and skipped beats. Care must be taken in differentiating thyroid and menstrual elements. The doctor may be the cause of onset of these symptoms, such as by excessive attention to the heart in Draft Board examinations. The cause may also be the emotional stress and strain arising in domestic difficulties. He described the anxiety attack when the doctor is called to a patient with anxiety feelings, palpitation and a fainting attack; sometimes the doctor occasions the further development of symptoms and chronic invalidism by prescribing digitalis to such a patient. It is unfortunate to have excessive attention focused on the heart in these individuals. The best treatment of cardiac neurosis is thus prophylactic. Avoid putting the patient to bed and giving drops. Make use of fluoroscopic and an electrocardiographic examination, and then assure him that there is no evidence of organic heart disease. Have him carry on in spite of symptoms, with a gradual stepping up of his activities. Tell him that you will assume full responsibility for any deterioration in his condition.

The general practitioner must know how to handle minor psychotherapy. Of course, major psychic cases must be sent elsewhere. Ask your patient with indigestion, "What is it in your life situation that you cannot swallow?" For the case of substernal oppression, "What is the load on your chest that you would like to get off?" It does take time. You must know all his problems, and relate his personal conflict to his bodily dysfunction. He must face up to the realism of the situation.

In the diseased heart, heart failure may be precipitated long before it is due because of the psychologic burden of anxiety. Hypertension is Public Enemy No. 1 and is often the cause of death. After years of debate as to which causes which, it is now conceded that hypertension causes arteriosclerosis, but little is known as to the cause of hypertension. It usually occurs in the tense, hard-driving dynamic individual, with the tension manifesting itself in the cardio-vascular system. One can safely say that "contention causes tension which causes hypertension". An unconscious rage often boiling below the surface comes out in the circulatory system. "He has an even disposition; he is always mad." The doctor cannot do much for hypertension itself; he cannot cut it out of the body. The patient must live with it, but must not get anxious about it. Try to relieve the anxiety; try to get rid of the hostility. Of course the psychic factor is but one of several causes of hypertension. Sedative drugs are of some value in psychosomatic medicine as a block between the tension and the functioning of the organs.

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## CAMDEN COUNTY

Joseph C. Lovett, M.D., Reporter

The monthly meeting of the *Camden County Medical Society* was held on December 5, 1944, at the City Dispensary with Dr. Henry B. Decker presiding. Twenty-seven members were present.

The speaker of the evening was COMMANDER W. T. REESE, U. S. N. R., who gave a very interesting talk of his experiences in the South Pacific. His

first service was with the Seabees. Later, he was transferred to the Base Hospital on the island, where patients were brought by plane. He then gave a detailed account of the duties on a fighting ship, the medical complement, operating room, etc.

During battle, there is a special set-up. The sick bay is abandoned. All water-tight doors are closed during action. First aid is given by the corpsmen and then the patients are moved to dressing stations. The crew must be trained as to handling the injured and what to do. It is very important that the men are taught to apply the tourniquet properly. The doctors are stationed in the turrets and are not allowed to leave until the action is over.

A great deal of progress has been made in the way of treatments during this war and more advancements will be made. When going into action, all must put on flash-proof clothing as there are a great many burns received. The treatment of burns is the simplest possible. They are cleansed thoroughly with soap and plenty of sterile water, fuel oil and dead tissues removed. Sterile vaseline strip gauze is applied, ordinary gauze over this, then waste cotton and pressure bandage. Morphine is given and plasma 1-unit (250 cc.) for each ten per cent of body area burned, sulfadiazine gms. II by mouth for first dose then gms. I q.2h. Dressing is not disturbed for ten days unless there are evidences of sepsis. Skin grafting is done in three weeks if needed.

He then told of the treatment of gun-shot wounds, fractures and head injuries. Where gas gangrene was present, early amputation was the treatment.

DRS. STRAUSS, ZEIGLER, AMATO and HALBEISEN were elected to membership.

Dr. Shipman, Chairman of the Insurance Plan Committee, stated the Plan had been approved by the Executive Committee and upon motion it was adopted by the Society.

Dr. Deibert read a resolution on the death of DR. B. F. BUZBY.

## HUDSON COUNTY

Harry J. Perlberg, M.D., Reporter

A regular meeting of the *Hudson County Medical Society* was held on December 5, 1944, at the Masonic Club, Jersey City, with DR. WALTER D. WEBER, President, presiding.

Dr. Ruoff, Chairman of the Health and Accident Insurance Committee, reported that his committee had gone into the various phases of health and accident insurance, and arrived at the conclusion that the state contract of the National Casualty Company is an advantageous one and has many features not included in other similar contracts, and that it would be to the best interests of the County Society to adopt this form of coverage at the earliest possible moment. Upon motion the plan was adopted.

DR. VINCENT A. SCIALLI of Jersey City was elected to membership. DR. JOHN ARENA of North Bergen transferred from the Medical Society of the County of New York.

In the absence of Dr. Samuel A. Cosgrove, Medical Director of Margaret Hague Maternity Hospital, Dr. James F. Norton acted as Chairman of the Scientific Session. DR. LEON SHULMAN presented two cases of adherent placenta, and DR. AMY CATTLEY presented a case of ovarian pregnancy.

DR. GEORGE GRAY WARD, F.R.C.O. and G. (Honorary), Clinical Professor of Obstetrics and Gynecology, Columbia University, and Chief Surgeon Emeritus, Woman's Hospital, spoke on "Experiences with Some Complicated Urinary Fistulae".

As an introduction to the discussion of his personal experiences with complicated urinary fistulae, Dr. Ward gave an interesting history of the surgical management of this lesion. He said that the earliest recorded case of urinary fistula is that of an Egyptian queen who reigned about 2050 B.C., whose mummy showed the presence of a large vesicovaginal fistula and a contracted pelvis. Until the middle of the nineteenth century these cases were considered incurable, as attempts at operative cure were rarely successful. In 1852 Marion Sims published his epoch-making paper demonstrating his successful technic—which depended on his discovery that the knee-chest position with retraction of the perineum would cause the vaginal walls to separate widely due to the vacuum created in the pelvis by the displacement of the intestines, and the fact that he used silver wire sutures which did not become infected as other suture material did in that pre-antiseptic age. A great advance was made by Mackenrodt in 1894, who developed the method of a wide separation of the vaginal wall from the bladder on all sides of the fistula and the separate suturing of the bladder and vagina. This had the advantage of overcoming tension of the bladder sutures which is essential for a cure, and which is sometimes the cause of failure by the classical Sims technic in certain cases. Trendelenberg advocated the abdominal approach, and Von Dittel later employed the transperitoneal route. Dr. Ward said that the vaginal route remains the preferable approach and is certainly safer than the abdominal operation which should be reserved for selected cases that are inaccessible due to fixation by scar tissue to adjacent structures. The flap-splitting technic with various modifications is the basis of the modern operative procedure in use today. That method and the classical Sims technic are most generally employed.

From his own records, Dr. Ward then reported twelve cases which presented unusual complications. His experience in these cases emphasizes the following conclusions, he said:

"1. An important point to remember before operating is that post-partum involution must be completed before attempting a repair; this will require at least two months—otherwise, the tissues will be too soft.

"2. Small fistulae often close themselves if a retaining catheter is used *promptly* post-partum or post-operation.

"3. Infection of the bladder and tissues, and phosphatic deposits must be eliminated.

"4. The relation of the ureters to the field of operation must be determined.

"5. All tension of the tissues must be relieved before suturing the fistula.

"6. Urethral fistulae should be closed transversely to avoid constriction.

"7. If the fistula is imbedded in scar tissue, the result of radiation or cautery, it is most important to dissect out this tissue, even if the fistula is enlarged thereby, as the lack of vascularity will be a cause of failure.

"8. When multiple attempts have resulted in failure with the flap-splitting technic, I have found the Sims operation with silver wire sutures often successful.

"9. Fistulae involving the internal vesical sphincter are often the most difficult cases to cure. While the fistula can be closed, control is absent because of the destruction of the muscle.

"10. Complete or partial destruction of the urethra can be remedied by the construction of a new urethra by using the technic suggested by Dr. Lilian Farrar. A self-retaining catheter should not be used in these cases. A small, straight, tied-in catheter is less apt to prevent healing at the vesical neck. It is often wiser to secure drainage by a suprapubic cystotomy, or through an artificial fistula made in the trigone.

"11. Lack of control may be overcome by the excellent operation recently devised by Dr. Aldridge of the Woman's Hospital, in which strips of the rectus fascia are brought down behind the symphysis and united around the urethra, or by the technic of Martius.

"12. In certain cases, the reversed Trendelenberg position is of advantage in closing large fistulae. The posture allows a clear view of the operative field due to the distension of the vaginal walls, and bleeding is less troublesome as it runs into the bladder.

"13. Rawls technic of dissecting the pubo-cervical fascia from the vaginal mucosa and overlapping it gives additional security to the flap-splitting operation.

"14. It is important to keep the urine acid after operation to prevent the formation of phosphatic deposits and calculi which may ulcerate through the scar of the operation.

"15. Time is necessary—and painstaking care.

"16. Haste will cause failure.

"17. It is easier to cure a fistula with the first operation. Multiple operations that have failed greatly increase the difficulty of cure.

"Finally, it should be remembered that no one procedure for the repair of vesical fistulae is adaptable to all cases. Each case is an individual problem, and the type of technic must be selected, or improvised to meet the conditions present."

DR. HENRY C. FALK of Harlem Hospital and DR. E. J. DALY discussed the paper. Discussion was terminated by Dr. Ward.

## PASSAIC COUNTY

Theodore Rothman, M.D., Reporter

A regular meeting of the *Passaic County Medical Society* was held in conjunction with the New Jersey Chapter of the American College of Chest Physicians on November 21, 1944, at the Valley View Sanitorium, Paterson.

The first speaker of the evening was DR. GRANT THORBURN, Chief of the Chest Service of the Lenox Hill Hospital, New York. His discussion dealt with the physician's first contact with tuberculous patient. He pointed out that a tuberculous patient should be immediately placed under adequate treatment, looking forward to his recovery. Slides were shown demonstrating recovery by various means of treatment.

DR. EDGAR MAYER, Professor of Medicine, Cornell University School of Medicine, discussed pulmonary emphysema, drawing attention to its onset associated with chronic bronchitis. He indicated that the basic pathology was a breaking down of alveolar walls with a subsequent reduction of the total number of alveolar respiratory surface. He found that it could be somewhat rapid in its onset and with an early fatal termination. Slides were shown.

## UNION COUNTY

F. W. Lathrop, M.D., Secretary

The *Union County Medical Society* met at the Ilderan Outing Club, Rahway, on November 8, 1944. The meeting was called to order by Dr. Bensley, President, at 9:00 p.m.

The minutes of the September 13 and September 27, 1944, meetings were accepted as printed in the Bulletin. The minutes of the Executive Committee meeting of November 6, 1944, were read and approved.

COMMUNICATIONS

1. Letter from Dr. Londrigan, President of the State Society, relative to the Selective Service System for New Jersey desiring the coöperation of The Medical Society of New Jersey in the program of assistance to veterans.

2. Letter from the Chairman of the State Veterans Service Committee, State Headquarters for Selective Service, referring to Dr. Londrigan's letter on the Veterans Assistance Program in New Jersey and expressing his appreciation for the cooperation of the State Society. The program is to be established on a local basis and the local committee will contact the County Society as the need develops.

MRS. JOSEPH WALDEN, Chairman of the Public Relations Committee, Eastern Union County Nursing Council War Services, was introduced and spoke briefly on the organization and its objectives.

Dr. Thomas H. Legget, member of the Board of Trustees of the Mental Hygiene Society of Union County, introduced MISS CATHERINE BASCHNAGEL, Executive Secretary and Chief Psychiatric Social Worker of the Society, who discussed the policies, principles of operation and its plans for Union County.

Dr. Bensley introduced MR. WILLIAM P. BRAUN, Defense Counsel of United States Fidelity & Guaranty Company on mal-practice cases, who spoke on "The Hazards and Pitfalls of the Practice of Medicine in Relation to Mal-practice Litigation". A very informative and instructive discussion followed Mr. Braun's talk.

LT. MANLEY C. WILLIAMS, M.C., of Rahway was elected to membership. DRS. DUPUY, TOLOR and ROTH were introduced to the Society and signed the Constitution.

# WOMAN'S AUXILIARY

## PRESIDENT'S NEW YEAR MESSAGE

Mrs. David B. Allman

As we enter a new calendar year I extend to you my sincere wishes for a happier and more unified existence.

Although we are beginning a "New Year", in terms of our Auxiliary activities our year is rapidly nearing its completion. In a few short months we will have our Annual Meeting, with new officers, new projects and new objectives.

I am happy to note that in the Counties I have had the pleasure of visiting their programs are well under way, and their work is progressing in a highly satisfactory manner.

We cannot, however, relax for a moment. The need for complete unity in Organized Medicine has never been greater. Eighty-five million people in the United States are demanding a method for the easier payment of the costs of unusual or prolonged illness. If State Medicine is to be avoided and the independence of the medical profession is to be preserved, the needs of the people must be met.

Although the Wagner-Murray-Dingell Bill, as such, is considered "dead", other bills to take its place are now being written. If the passage of this type of legislation is to be forestalled we must act in unison to prevent it.

Your attendance at all County meetings is essential, for only in that way can you keep thoroughly informed. We must coöperate with The Medical Society of New Jersey in every way, not only in this matter but in all matters pertaining to the protection and the advancement of the practice of medicine. Our friends and relatives in the armed services expect at least that much of us. We must not fail them.

## HYGEIA

Mrs. Frederick G. Wandall, Chairman

*Hygeia* is finding its rightful place in more and more physicians' waiting rooms. Other waiting rooms such as those of dentists, lawyers and beauticians, have *Hygeia* on their tables.

One of the objectives of our own Auxiliary to the American Medical Association is "to interpret the aims of the medical profession to other organizations interested in the promotion of health education". One way to interpret these aims is through *Hygeia*.

*Hygeia* prints only authentic health information.

*Hygeia* gives in clear, concise and simple terms, scientific knowledge of the medical world that even the school child will understand.

*Hygeia* gives reliable information regarding quacks, faddists and cultists. It is a safeguard against ignorance.

These are only a few of the objectives of *Hygeia*.

The endorsement of many state medical societies indicates that the medical profession in general appreciates the importance of *Hygeia*. The public is seeking reliable health information other than what it receives at the hands of the family physician. It is better that this information come from an authentic source, such as *Hygeia*, published by the American Medical Association.

So we hope that when a physician who is not a subscriber to *Hygeia* is approached by an Auxiliary member, he will have an open mind and a listening ear to what she has to say.

Our goal is: *Hygeia* in every waiting room of every physician in the state.

## FUTURE EVENTS

Essex—On Thursday, January 11, 1945, at 9:00 p. m. a joint meeting will be held with the Essex County Medical Society at the Academy of Medicine, followed by a collation.

Following dessert at 12:30 a regular business meeting is scheduled for 1:00 p. m. on Monday, January 22, 1945. The second Public Relations Symposium will be held at 2:30 p. m.

Gloucester—A "Husbands' Party" will be held on January 27, 1945, at 9:00 p. m. at the home of Mrs. F. G. Wandall in Clayton.

Middlesex—The January 16, 1945, meeting will be held at the home of Mrs. Charles Merrill, Highland Park, at 8:30 p. m. The theme of the meeting will be "Cancer Control".

Passaic—Mrs. David B. Allman, President of the State Auxiliary, will speak on "Auxiliary Work" at the January 15, 1945, meeting which will be held at 2:30 p. m. at the home of Mrs. Richard McDonald, Paterson. Miss Viola Boyd will entertain with piano selections.

## AUXILIARY REPORTS

### Essex County

Mrs. Rocco Marra, Chairman of Publicity

A joint meeting of the Contemporary Club of Newark and the *Woman's Auxiliary to the Essex County Medical Society* was held on November 28, 1944, at the Academy of Medicine. The meeting was presided over by Mrs. Lodovico Mancusi-Ungaro. Messages of welcome were given by Dr. Louis Schneider, President of Essex County Medical Society, and Mrs. Ernest C. Reock, First Vice-President of Contemporary, who acted in place of Mrs. Reyburn A. Higgins, President. Guest speakers were: Mrs. John H. Barry of Contemporary, Mr. Rowan Whealdon, Executive Secretary of the Essex County Tuberculosis League, and Capt. Herbert X. Spiegel, Army Surgeon and Instructor in Psychiatry at Mason General Hospital, Brentwood, L. I.

The program was arranged by Mrs. S. Bernard Kaplan of the Public Relations Committee of the Auxiliary and Mrs. Frank S. Forte, Chairman of Contemporary's Health Committee. Mrs. Forte introduced Capt. Spiegel.

Tea was served by the Auxiliary's Hospitality Committee, headed by Mrs. J. Wallace Hurff.

Mrs. Barry, representing the Speakers' Bureau of Newark Chapter, Red Cross, told of the continuing need of nurses for the armed services. She spoke also of the need of nurses in civilian life and urged women who have had nurse's training to serve in hospitals at least part time.

Mr. Whealdon appealed for continued interest in the Tuberculosis League's work and asked that the two groups which arranged the meeting assist in the sale of Christmas seals.

Capt. Spiegel dwelt especially on men suffering from psychoneurotic conditions and the widespread misunderstanding of such cases. There are many such persons leading normally active lives and many men with such disturbances serving successfully in the armed forces, the speaker pointed out. The men will be sensitive to the attitude of the people who receive them when they come home, he said, adding that most of all they will want to be treated as individuals. "We hear them spoken of as G. I. Joe as though they were one man," he stated. "G. I. Joe thinks this or that. The only thing common to all of them is the uniform." They do not want to be dealt with sentimentally or patronizingly, Capt. Spiegel asserted. "They do not want to be called 'our boys'. It is meant to be warm and sympathetic but it sounds patronizing. They are men doing men's work. It is not to be wondered that it arouses resentment." The speaker suggested that the returned soldier should be made to realize his service was appreciated. Most important, he said, is the urgent necessity of letting the soldier help himself; he should not be encouraged to lead a parasitic life. Capt. Spiegel served in the Tunisian and Italian campaigns, and returned to this country after being treated for a severe leg wound.

### Gloucester County

Mrs. Clarence Bowersox, Chairman of Publicity

Mrs. Louis Collins of Glassboro entertained the *Woman's Auxiliary to the Gloucester County Medical Society* at a luncheon on November 30, 1944. Following the luncheon a regular business meeting was held, with Mrs. Fred Faux, Vice-President, presiding.

### Mercer County

Mrs. C. Chester Chianese, Chairman of Publicity

While members of the *Woman's Auxiliary to the Mercer County Medical Society* made surgical dressings for the McKinley Memorial Hospital on December 1, 1944, they listened to Mr. William B. Meytrott, Superintendent of the Hospital, speak on "Post-War Expansion", and Dr. Ernest F. Purcell, President of the Staff of the Hospital, on "Cancer Control".

### Middlesex County

Mrs. Norman Rosenberg, Chairman of Publicity

The *Woman's Auxiliary to the Middlesex County Medical Society* met on December 20, 1944, at the home of Mrs. Robert Walker, Highland Park. Mrs. Charles F. Merrill, President, presided. Cards and games were enjoyed.

An auction sale was held to raise funds for the organization.

Each member voluntarily contributed a Christmas box for a hospital patient at Camp Kilmer.

### Warren County

Mrs. Herman Baldauf, Chairman of Publicity

The *Woman's Auxiliary to the Warren County Medical Society* held a Christmas dinner party at Harker's Hollow with their husbands as guests. Mrs. F. A. Shimer, President, welcomed the guests and called on Dr. Herman Baldauf, President of the County Medical Society, and Dr. F. A. Shimer, Chairman of the Advisory Committee, for brief speeches.

## BOOKS RECEIVED FOR REVIEW

Control of Pain in Childbirth; Anesthesia, Analgesia and Amnesia. By Clifford B. Lull, M.D., F.A.C.S., and Robert A. Hingson, M.D., with an Introduction by M. Vaux, M.D. Pp. 356 with 100 illustrations, and 32 subjects in color. Philadelphia, J. B. Lippincott Co. 1944. $7.50.

Symptoms of Visceral Disease; A Study of the Vegetative Nervous System and Its Relationship to Clinical Medicine. By Francis Marion Pottenger, A.M., M.D., LL.D., F.A.C.P. 6th ed. Pp. 442 with 87 illustrations and 10 color plates. St. Louis, C. V. Mosby Co. 1944. $5.00.

Atlas of the Blood in Children. By Kenneth D. Blackfan, M.D., and Louis K. Diamond, M.D., with illustrations by C. Merrill Leister, M.D. Pp. 320. New York, The Commonwealth Fund. 1944. $12.00.

Medical Uses of Soap; A Symposium. By G. Thomas Halberstadt, B.S., Ch.E.; Marion B. Sulzberger, M.D.; Theodore Cornbleet, M.D.; Lester Hollander, M.D.; C. Guy Lane, M.D.; Daniel J. Kooyman, Ph.D.; Rudolf L. Baer, M.D.; Carey McCord, M.D.; Morris Fishbein, M.D., and Irvin H. Blank, Ph.D. Edited by Morris Fishbein, M.D. Pp. 182 with 41 illustrations. Philadelphia, J. B. Lippincott Co. 1945. $3.00.

## BOOK REVIEWS

**Pain.** Proceedings of the Association for Research in Nervous and Mental Disease. Research Publication, Vol. 23. Pp. 468, with 116 illustrations and 19 tables. Baltimore, The Williams & Wilkins Co. 1943. $7.50.

The fact that the subject of pain was selected for investigation by the Association would indicate that knowledge of "pain" is far from complete. Thirty-two papers constitute the volume which contains information, "some old, some new", regarding the various aspects of the subject. It contains papers on the perception and measurement of pain, and various theoretical and experimental aspects. In addition to the information contained in the papers, the discussions of the presentations are valuable and illuminating.

The research scholar and the clinician will find much material of interest. C. C. Beling, M.D.

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**Fertility in Men:** A Clinical Study of the Causes, Diagnosis and Treatment of Impaired Fertility in Men. By Robert Sherman Hotchkiss, B.S., M.D. Pp. 216 with 95 illustrations. Philadelphia, J. B. Lippincott Co. 1944. $3.50.

This monograph of a little over 200 pages gives a concise and a most instructive evaluation of clinical and experimental work in male sterility to date.

Among the recent investigators in the field, Dr. Hotchkiss ranks very high indeed; his valuable contributions since 1935 have helped to clarify many controversial phases of this problem.

The chapter on histopathology of the male generative tract with its excellent illustrations is particularly recommended. The chapter on the metabolism of the spermatozoa and the chemical composition of semen is illuminating and the injurious effects of vitamin A and E deprivation are clearly stated. No great significance is attributed to vitamin B or C deprivation on the sperm production, morphology or motility.

It is interesting and gratifying to note that an investigation of Dr. Hotchkiss' stature has obtained satisfactory results with the administration of pituitary and chorionic gonadotrophins in many cases of male sterility due to profound oligospermia of long standing. These results were obtained in spite of the fact that the potency of the gonadotrophic products now available is still rather low for the human. With the improvement in the concentration of the hormones it is hoped that the percentage of favorable responses will increase.

Rita S. Finkler, M.D.

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**Fertility in Women:** Causes, Diagnosis and Treatment of Impaired Fertility. By Samuel L. Siegler, M.D., F.A.C.S., with foreword by Robert Latou Dickinson, M.D. Pp. 450 with 194 illustrations including 40 subjects in full color on 7 plates. Philadelphia, J. B. Lippincott Co. 1944. $4.50.

The attitude of the author in making the headline of the book "Fertility" instead of sterility should be appreciated, because it stresses the positive side of the problem. We must become aware of the fact that amenorrhea and schizophrenic processes or depressive psychoses were found together in 30 to 40 per cent in recent statistics.

The book, though very systematic, serves practical purposes foremost; the many illustrations covering nearly all sections, particularly the endocrine. The excellent diagrams and the precise diction make this monograph rather didactic.

To include a few pages on comparative physiology of reproduction is commendable. The section on the tubal factor is enlightening as is the one dealing with the innumerable potency tests. Dr. Siegler states the danger of uterine pessaries which are not contraceptives and cannot prevent pregnancy, but can cause abortion due to constant contractions of the uterine muscle. All uterine applications except modern conization, are rather dangerous and their use should be discouraged.

It might be appropriate to add, in a new edition, a section on the occupational influence on fertility since thousands upon thousands of women are doing work now which they never did before.

This book will be helpful for both the general practitioner and the specialist. The beginner will find it a practical guide, indeed.

Herbert Steiner, M.D.

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**Analysis and Interpretation of Symptoms.** Edited by Cyril M. MacBryde, M.D. Reprinted from Clinics 2: 1343-1644, April 1944. Philadelphia, J. B. Lippincott Co. 1944. $4.00.

To every general practitioner and clinician this book represents a refresher course in the correlation of clinical problems and physiological pathology. Although it serves its most useful purpose as a reference book the chapters on the various symptoms are so clearly and interestingly compiled as to merit the reader's attention throughout.

I daresay few clinicians, if any, can read through these chapters dealing with nervousness and fatigue, fever, headache, thoracic pain, cough and hemoptysis, abdominal pain and obesity without recalling some especially puzzling case whose symptoms now appear more significant and less enigmatic.

The book can be sincerely recommended as an interesting review in its analysis of the too frequent vague symptoms enumerated above.

Arthur D'Alessandro, M.D.

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**Plaster of Paris Technic.** By Edwin O. Geckeler, M.D. Pp. 220 with 208 illustrations. Baltimore, The Williams & Wilkins Company. 1944. $3.00.

This book on plaster of paris technic is beautifully illustrated. The author covers all phases of the subject and gives the more common uses of plaster of paris. However, the use of this material is an art and like any art it is difficult to learn from a book. It is hoped that teachers in our medical schools will be enough interested by the book to see that students be given a start in its use.

The book is recommended to all doctors who use plaster of paris; the illustrations alone should sell this monograph. T. Nicola, M.D.

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**Malaria:** Its Diagnosis, Treatment and Prophylaxis. By William N. Bispham, Col. U. S. Army, retired. Pp. 197, 5 plates. Baltimore, The Williams & Wilkins Company. 1944. $3.50.

The problem of malaria, its diagnosis and treatment is authoritatively discussed. All the chapters have been reviewed by experts in the various phases of the disease prior to publication.

There is a short history and geographic distribution of malaria. The discussion of the etiology covers the morphology and the life cycle of the malaria plasmodia. There is a schematic drawing of the malarial with plates of the typical plasmodia. The cycle in man, the cycle in the mosquito, and the gametocytes of the malaria plasmodia are simply explained. A chapter covers the mosquito — its anatomy, feeding and breeding habits with a practical list of mosquitoes which transmit malaria.

In the epidemiology, the incidence of malaria and its spread, the following simple facts are stressed: (1) The presence of anopheles mosquitoes which are good vectors of the disease; (2) the presence of suitable breeding places for anophelines, and accessible local collections of non-immune population; (3) human beings with gametocytes of the malarial parasites in the peripheral blood must be accessible to and bitten by the vector; (4) the temperature must favor the completion of the life cycle of the parasite in the mosquito.

Care is exercised in differentiating the symptoms of vivox malaria, falciparum malaria and malariae malaria, each being discussed as to paroxysms, temperature curves, subcontinuous fevers, and the special symptoms of malaria. Under diagnosis there is stressed laboratory methods and differential diagnosis. Methods of treatment together with different drugs, their pharmacology, dose and method of administration are outlined. The status of drug prophylaxis, protection of man from the bite of mosquitoes and malarial surveys in the prevention of malaria are well covered. The topic of malaria immunity, a controversial subject, is viewed from what is fact and what is theory, and present attitudes are given from observers in different parts of the world. A rather complete chapter is devoted to blackwater fever. Martin Oransky, M.D.

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**Operations of General Surgery.** By Thomas G. Orr, M.D. Pp. 723 with 1396 step-by-step illustrations on 570 figures. Philadelphia, W. B. Saunders Co. 1944. $10.00.

Dr. Orr has written an excellent book in a simple, straight-forward manner, easy to read and to follow step by step. The historical and antiquated types of operations have been omitted, hence, a reader has not the difficult task of deciding which is the best and most up-to-date method to follow. The illustrations are well chosen and show clearly the consecutive steps of all the important operations. There are very few original illustrations.

Many important but seemingly minor details on which the success of many operations depend, which many surgeons have had to learn by the hard road of experience, are very carefully and explicitly stated. The chapters on wound healing and treatment of fresh wounds are unusually well expressed. Particular attention is given throughout the book to the different methods of suturing, especially in the chapters on abdominal incisions and the digestive system, with excellent reproductions of each procedure. The article on the bones and joints, while well done, omits so many procedures that the true value of this part of the book is somewhat questionable.

This is a book which every surgeon could well have in his library with profit.

Thomas W. Harvey, Jr., M.D.

# Tuberculosis Abstracts

## *A Review for Physicians*

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

**Vol. XVIII** **January, 1945** **No. 1**

UNSUSPECTING carriers and spreaders of the tubercle bacillus comprise a numerically small but important minority of the population. Though most general hospitals dislike to receive known cases of pulmonary tuberculosis for treatment of unrelated conditions, their patients and personnel nevertheless remain under constant threat of tuberculous infection. This condition obtains because simple, adequate measures are not taken by the institution to detect among the employees, staff and persons admitted as patients the presence of unrecognized or unreported tuberculosis.

## TUBERCULOSIS CONTROL IN HOSPITALS

Few hospitals will accept tuberculosis of the lung as a disease to be treated within their walls except the large public institutions with special facilities for that purpose. Recently private hospitals in Chicago were asked:

1. Do you admit patients with pulmonary tuberculosis to your hospital for treatment of that disease?
2. Do you admit patients with known pulmonary tuberculosis to your hospital for treatment of other conditions?

Of the 73 hospitals which replied, 5 answered question one with "Yes;" 68 with "No;" 25 replied to question two with "Yes" and 48 with "No" or with comments which amounted to a negative reply. The answers indicated that hospital administrators do not consider the admission of the tuberculous an asset to hospital service. In fact many of them thought this was an attempt to uncover an administrative deficiency.

In a community with sufficient beds available in tuberculosis hospitals this attitude does not hamper phthisiotherapy, although in the past physicians have been deprived of facilities to hospitalize their patients in this manner. With the increase of surgical treatment this has often proved hampering. In communities with inadequate facilities for the treatment of tuberculosis failure to exploit all the available space, especially when numbers of general hospital beds were vacant, has seemed unjustified.

### Fear of Infection

The reason for this is the fear of infecting nontuberculous patients and hospital personnel housed under the same roof. This precaution might be justified if the refusal could really lead to a hospital atmosphere free of tubercle bacilli, but that is not the case.

In recent years, since we have become aware of obscure tuberculosis, our distrust of a negative history and physical examination has become deep-seated and justified. Again and again evidence has shown that any hospital may have patients with unknown and open pulmonary tuberculosis in its rooms and wards however little the ailment for which these persons were admitted may have to do with pulmonary disease.

### Routine Chest X-rays

Only universal X-ray examinations of the chest of all patients, regardless of the nature of their complaint, could lead to exclusion of the tuberculous. The University of Chicago Clinics and the affiliated Provident Hospital have X-rayed all clinic admissions for some years with most beneficial results. As a method of avoiding contamination, however, this is only part of the necessary effort. As a means of keeping tuberculosis out of hospitals, pre-admission X-rays would lead to an unnecessary increase in the rejection of patients badly in need of care.

Many patients will always enter hospitals with-

out a previous examination, and they cannot be asked to leave if tuberculosis is discovered. Even if a discharge could be effected without harm to the patients, where should they go for treatment? Tuberculosis hospitals could hardly be expected to engage in the treatment of all extrapulmonary non-tuberculous conditions. Sanatoria are usually not located or staffed for the purposes of general medicine and surgery. Many communities have no facilities specifically intended for the treatment of patients with tuberculosis.

## Danger of Unrecognized TB

General hospitals should accept the necessity of housing tuberculous patients. The danger of infection arises from not recognizing their pulmonary infection, as has been the unavoidable fact up to now.

Proper isolation in one wing, floor, or section of the building is easily accomplished. At the University of Chicago Clinics this has been done during the past twelve years. Through knowing who and where our tuberculous patients are we are avoiding the most acute danger of contamination which always arises where germs are being spread without the knowledge of either the distributor or the recipient.

## Staff Examination

Isolation protects the medical and nursing staff and other employees against infection from the patient. However, to make tuberculosis control in a hospital complete, physicians, nurses, attendants, etc., have to be protected not only from patients but from each other and patients have to be guarded against infection from members of the personnel.

Nearly 15 years ago when the University Clinics introduced X-ray examination of the chest by roentgenograms for all nurses, the supervisor of the operating rooms and the nurse in charge of the sterilizing room for the newborn were found with active tuberculosis. Neither was aware of her condition. Stereoscopic roentgenograms were then made obligatory for all physicians and nurses on taking employment, with re-examinations every year for those on general duty and every three months for the personnel of the tuberculosis division.

## General Hospital Personnel

Other personnel were exempt from this routine. About a year later, positive sputum findings began to be reported in patients where no other findings suggested tuberculous infection. The clinical findings in most of these patients suggested upper respiratory or bronchitic involvement. The suggestion that an X-ray examination of the chest of the members of the laboratory staff be made was resented by that staff and rejected by administrative officers.

Eventually, it was found that the laboratory worker in charge of sputum tests, a plump and healthy appearing girl, had extensive cavernous tuberculosis with an almost pure culture of acid fast bacilli in her sputum. She had contaminated the patients' specimens. The embarrassment of apologizing to the patients in question and of revoking the reports to the health department had a most beneficial effect. Roentgen examination of the chest has since been obligatory for all staff members and hospital employees and has been gratefully received by almost all of them.

## Sincere Effort Needed

Experiences like this may seem extraordinary. The author believes they appear so only because there has been no great drive to uncover tuberculosis in hospital personnel. There can be no cause for the hesitation on the part of the general hospital to put its house in order with regard to tuberculosis other than inertia and the fear of administrative commotion.

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*Tuberculosis Control in Hospitals, Robert G. Bloch, M.D., The NTA Bulletin, August, 1944.*

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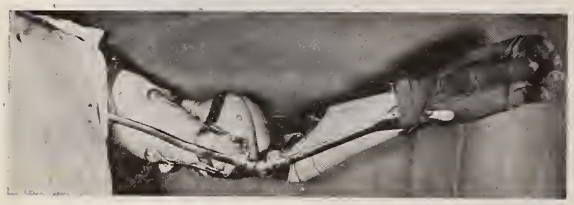
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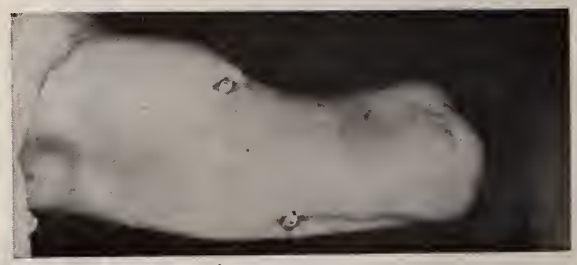
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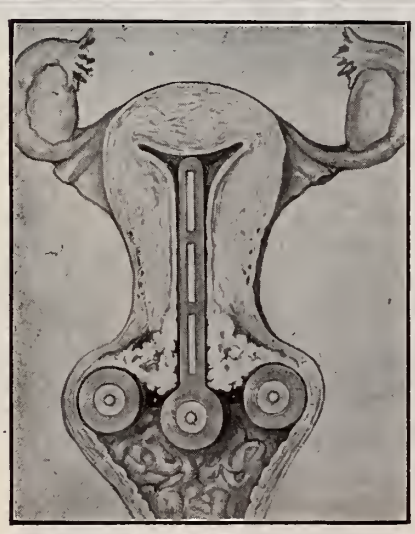




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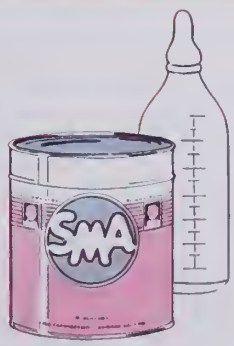
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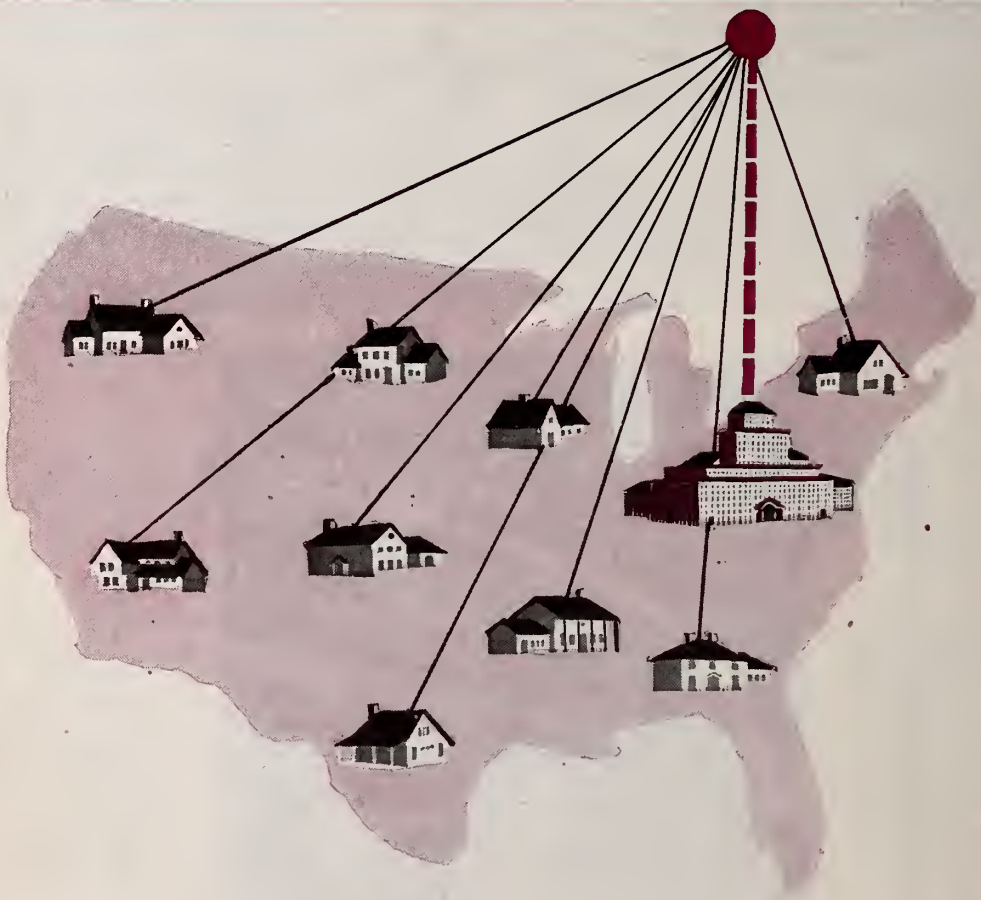
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1. Tracy Putnam: Convulsive Seizures, p. 4, J.B. Lippincott Co., 1943.

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*R. H. Follis, D. Jackson, M. M. Eliot, and E. A. Park: Prevalence of rickets in children between two and fourteen years of age, Am. J. Dis. Child. 66:1-11, July 1943.

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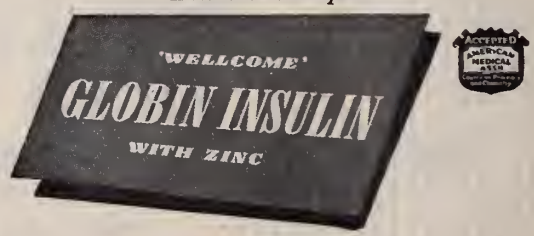
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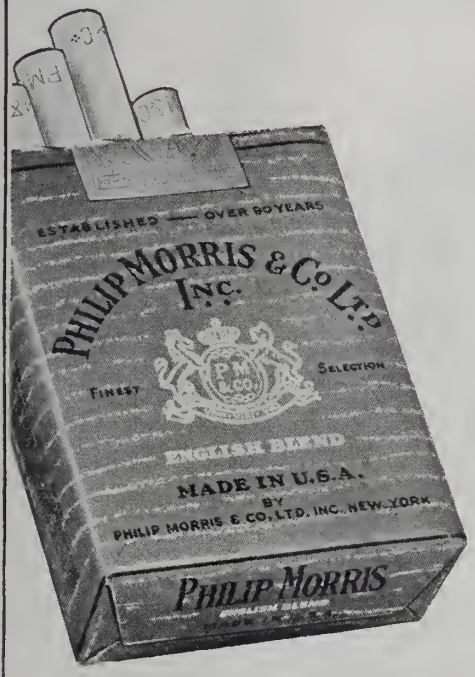
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*Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154. Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60. Proc. Soc. Exp. Biol. and Med., 1934, 32, 241. N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592.

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(1) West. J. Surg., Obst. & Gyn., 51:150, 1943; (2) Clin. Med. & Surg., 46:327, 1939; (3) Am. J. Obst. & Gyn., 46:259, 1943.

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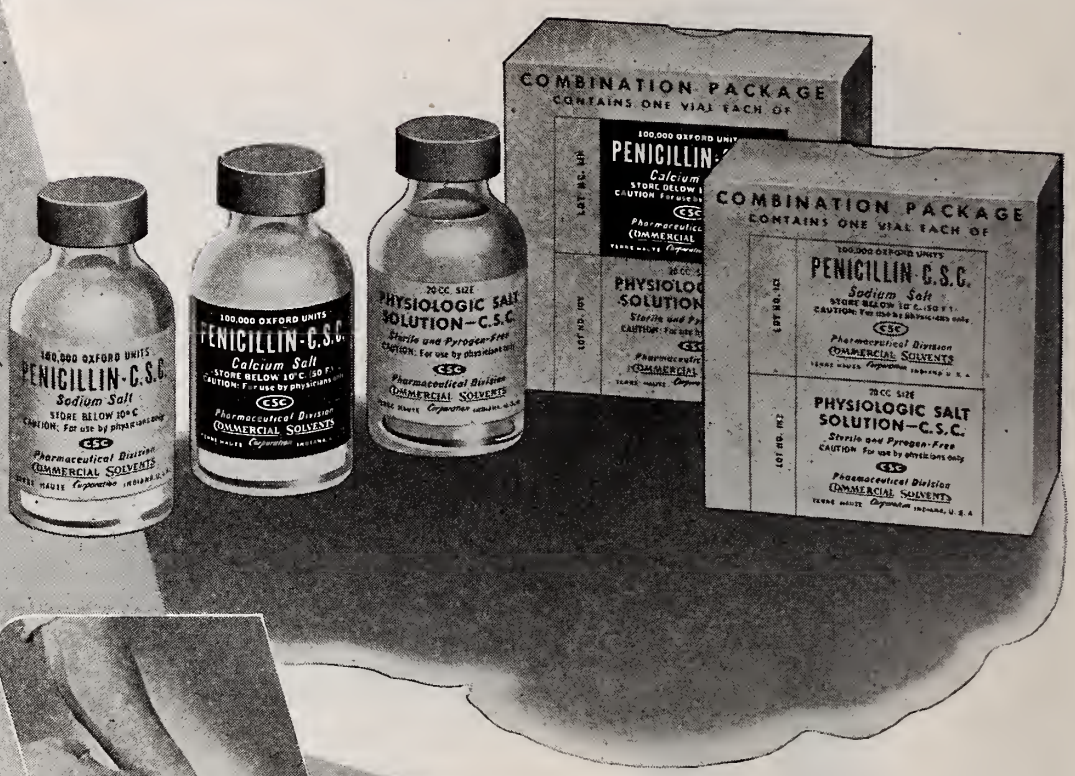
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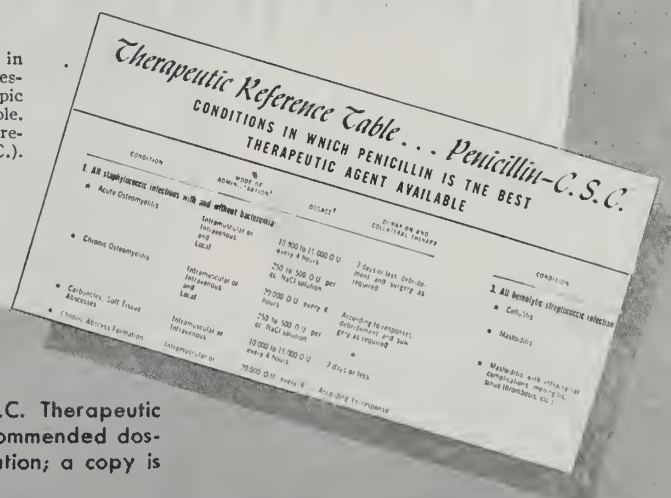
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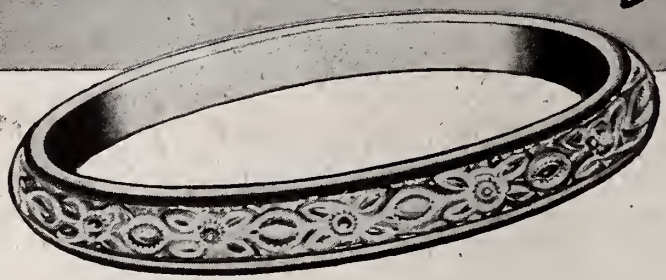
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BENZESTROL
(2, 4-di (p-hydroxyphenyl)-3-ethyl hexane)
*Formerly called by the trade name OCTOFOLLIN*

In estrogen therapy the physician is particularly interested in clinical efficacy and freedom from toxic side reactions. In BENZESTROL, Schieffelin & Co. offers a significant contribution to hormone therapy in that it is both estrogenically effective and singularly well tolerated whether administered orally or parenterally.

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Potencies of 0.5, 1.0, 2.0, 5.0 mg.
Bottles of 50, 100 and 1000.

**BENZESTROL SOLUTION**
Potency of 5.0 mg. per cc. in 10 cc.
Rubber capped multiple dose vials.

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Original illustration from Principles and Practice of Obstetric Medicine, by D. D. Davis, M.D., London, 1836.

# TO EASE THE BURDEN

It is the province of the physician to assist the patient through difficult periods of life, whether they be the result of structural or functional defects, and to contend with those conditions which oppose natural, healthy functioning of the human body. Schering is privileged to share this province by developing and providing new and rational therapeutic agents for the physician which enable him effectively to combat many of the problems of adolescence, pregnancy, and the menopause.

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# There is an important difference between Acidophilus and Buttermilk

FROM TIME TO TIME, many physicians may ask themselves, "Shall I prescribe *buttermilk*—or would *Acidophilus* be worth its slightly higher cost?"

If the disorder under treatment is intestinal, a helpful guide is this: *It is an established fact that the only organism in the sour milk group which will live and grow in the intestinal tract is L. acidophilus . . . present only in Acidophilus.*

**In prescribing Acidophilus, remember that Walker-Gordon Acidophilus has three important advantages:**

**1.** It is prepared from Walker-Gordon Certified Milk (2% butter-fat)—acknowledged to be the finest milk in the world.

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**3.** Tests at times of bottling show bacilli counts averaging over 500,000,000 per c.c.—considerably above the acceptable standards.

***We believe that it is impossible to buy a more effective Acidophilus—anywhere***

# WALKER-GORDON
## Acidophilus

(For information on clinical tests with Walker-Gordon Acidophilus, write to Walker-Gordon Laboratories, Inc., Plainsboro, New Jersey.)

**Phone the nearest Borden branch, or call WAlker 5-7300. Or order it from your milkman.**

# *Physicians know from clinical experience*

*the reliability of*

## Pil. Digitalis

*(Davies, Rose)*




**They conform now,**
**as in the past,**
**with U.S.P. requirements**

Each pill is equivalent to 1 U.S.P.XII Digitalis Unit. "One United States Pharmacopoeial Digitalis Unit represents the potency of 0.1 Gm. of the U.S.P. Digitalis Reference Standard."—U.S.P.XII.

Made from Powdered Digitalis Leaf, PIL. DIGITALIS (*Davies, Rose*) present all of the therapeutic principles obtainable from the drug.

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*It gives uniformly good results*

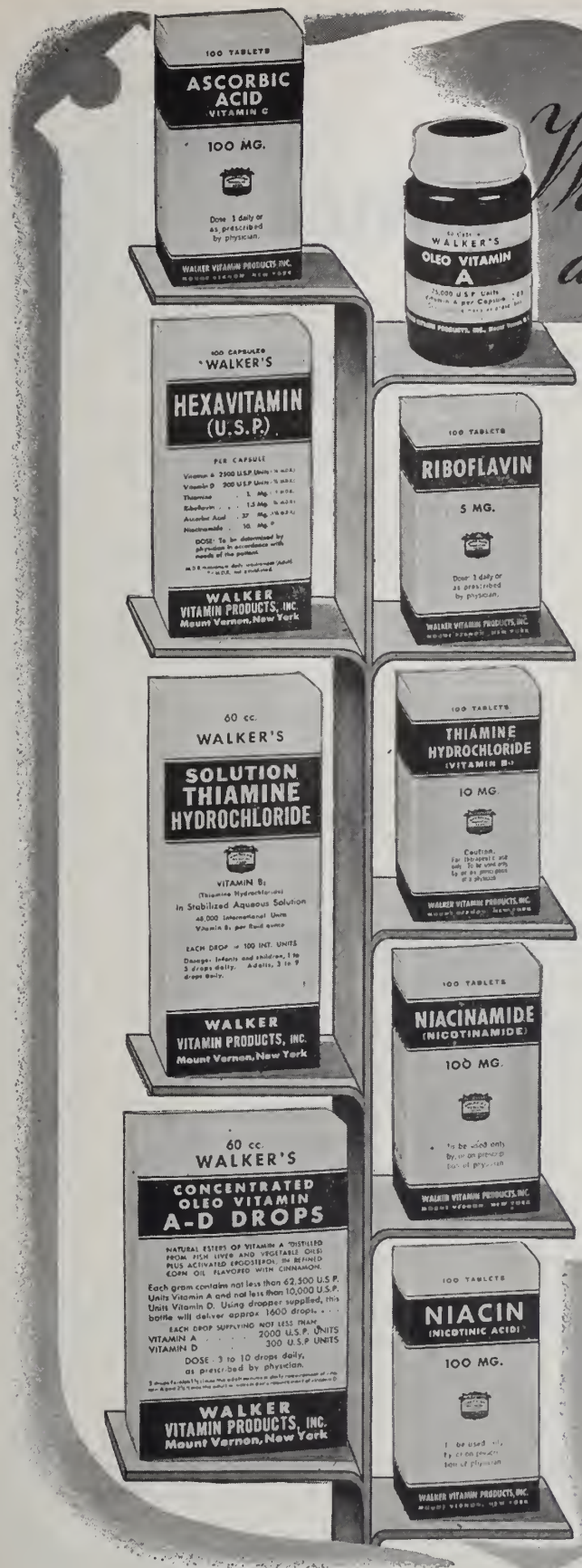
• A powdered, modified milk product especially prepared for infant feeding, made from tuberculin tested cows milk (casein modified) from which part of the butter fat is removed and to which has been added lactose, olive oil, cocoanut oil, corn oil, and fish liver oil concentrate.

*One* level tablespoonful of the Similac powder added to each *two* ounces of water makes 2 fluid ounces of Similac. The caloric value of the mixture is approximately 20 calories per fluid ounce.

ACCEPTED AMERICAN MEDICAL ASSN. Council on Foods

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# *Walker vitamins are good vitamins*

. . . **Good** for physicians to prescribe because they fill real therapeutic needs with efficiency, and conform to the highest ethical standards of quality. **Good** for patients to take because careful laboratory control assures consistent uniformity of vitamin potencies, and because they are convenient to take. **Good** also, because they offer physician and patient alike, pharmaceutically elegant vitamin preparations at commendably low prices.

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(1 Mg., 3 Mg., 5 Mg., 10 Mg.)

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(1 Mg., 5 Mg.)

**Ascorbic Acid**
(25 Mg., 50 Mg., 100 Mg.)

**Niacin**
(25 Mg., 50 Mg., 100 Mg.)

**Niacinamide**
(25 Mg., 50 Mg., 100 Mg.)

**SOLUTIONS**

**Solution Thiamine Hydrochloride (Oral)**
(100 I.U. per drop)

**Concentrated Oleo A-D Drops**
(2000 I.U. A and 300 I.U. D per drop)

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**Oleo Vitamin A Capsules 25,000 I.U.**
**Hexavitamin U.S.P.**

*Walker*

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*We repeat that*

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# THE CASUAL REMARK

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In this way you know you will receive a complete diagnosis on your patient's eyes.

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## DECONGESTIVE BUT NOT RE-CONGESTIVE

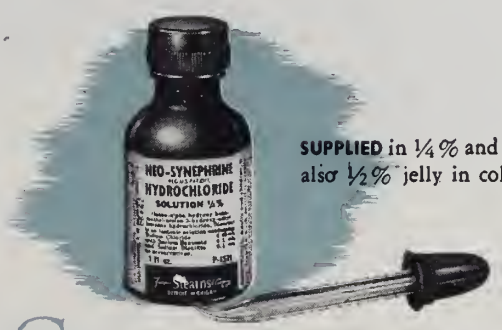
• Neo-Synephrine produces prompt and enduring nasal decongestion, without compensatory re-congestion. When the cause of congestion is removed, Neo-Synephrine may be discontinued immediately without aggravation of symptoms.

# Neo-Synephrine

## HYDROCHLORIDE

*LAEVO-α-HYDROXY-β-METHYLAMINO-3-HYDROXY-ETHYLBENZENE HYDROCHLORIDE*

**FOR NASAL DECONGESTION**




**SUPPLIED** in ¼% and 1% solution, bottles of 1 fl. oz., also ½% jelly in collapsible tube with applicator.

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DETROIT 31, MICHIGAN

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### FACTS ABOUT NEO-SYNEPHRINE

**PROMPT,** prolonged nasal decongestion through local vasoconstriction following topical application.

**EQUALLY EFFECTIVE** upon repeated use.

**WELL TOLERATED** locally, the solutions are isotonic and virtually non-irritating to nasal mucosa.

**CILIARY ACTION** is not appreciably impeded.

**RELATIVE FREEDOM** from systemic effects widens the range of usefulness for Neo-Synephrine—manifestations of central nervous system stimulation are rarely observed.

**INDICATED** for symptomatic relief in the common cold, sinusitis, nasal manifestations of allergy, and similar conditions.

**ADMINISTRATION** may be by dropper, spray, or tampon.

**FURTHER FACTS FOR YOUR REFERENCE FILE WILL BE GLADLY SENT ON REQUEST**

TRADE MARK NEO-SYNEPHRINE—REG. U.S. PAT. OFF.



## *The Latest Spirochaeticide*

acceptable to the United States Public Health Service for the new rapid treatment of syphilis (August 31, 1944) is Dichlorophenarsine Hydrochloride, U. S. P. This newest anti-luetic is made available by E. R. Squibb & Sons as

**Clorarsen**
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Today— NESTLÉ's Lion Brand Milk has a NEW LABEL . . . and a great new value!




# 400 UNITS OF VITAMIN $D_3$*

# PER PINT




ACCEPTED AMERICAN MEDICAL ASSN Council on Food

WISCONSIN ALUMNI RESEARCH FOUNDATION Approved for VITAMIN D upon periodic tests

## UNDER THIS NEW LABEL

—this new, improved milk replaces NESTLÉ's Lion Brand

Today—to meet a recognized need—Nestlé's has produced an improved evaporated milk with *greatly increased Vitamin D.*

*25 USP units of IRRADIATED 7-DEHYDROCHOLESTEROL have been added to each fluid ounce—so that this *new* Nestlé's Milk supplies 400 USP UNITS OF VITAMIN $D_3$ per reconstituted quart.

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So the extra advantages of NESTLÉ's Evaporated Milk will be available to everyone—despite the increase in Vitamin D, there has been *no increase in price.*

No feeding instructions furnished to the laity.

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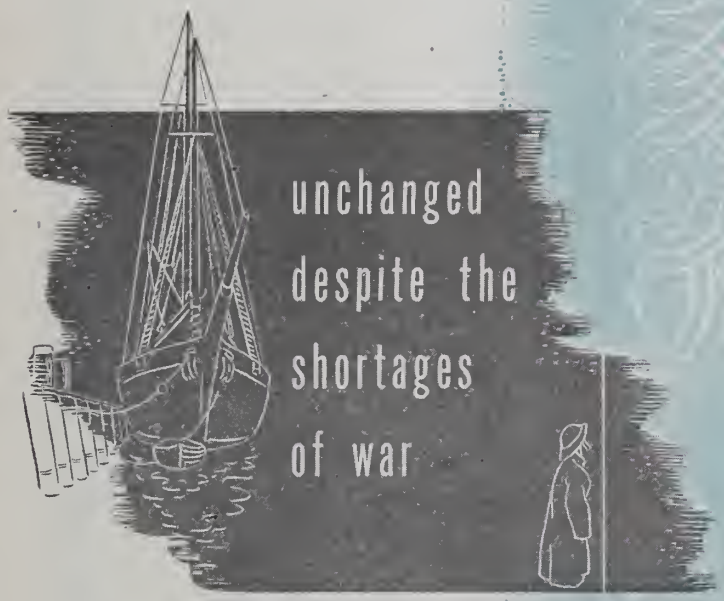
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*you can still prescribe — and your patients can still obtain — the natural vitamins of time-honored cod liver oil itself, in the three pleasant dosage forms of*

# white's cod liver oil concentrate

. . . drop dosage for infants; tablets for youngsters and adults; capsules for somewhat larger dosage, or wherever capsular medication is preferred.

## No Increase in Cost-to-Patient

Despite its advantages in potency, stability, palatability and convenience, the cost of White's Cod Liver Oil Concentrate has always compared favorably with that of plain cod liver oil. Current shortages, however, have resulted in much higher prices for the plain oil, while the price to patient of White's Cod Liver Oil Concentrate has been maintained at its established economy level. Prophylactic antirachitic dosage for infants STILL costs less than a penny a day. Council accepted; ethically promoted. White Laboratories, Inc., Pharmaceutical Manufacturers, Newark 7, N. J.

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buy more
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## MILK DIFFUSIBLE *Vitamin* D PREPARATION

DRISDOL in Propylene Glycol makes it possible to secure the benefits obtainable from combining vitamin D with the daily milk ration. This preparation is simple, convenient and easy to use, and relatively little is required for prophylaxis and treatment of rickets—*only two drops daily.*

*does not float on milk*
*does not adhere to bottle*
*does not have a fishy taste or odor*

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ACCEPTED AMERICAN MEDICAL ASSN. Council on Pharmacy and Chemistry

Drisdol in Propylene Glycol—10,000 units per Grom—is available in bottles containing 5 cc. and 50 cc. A special dropper delivering 250 U.S.P. vitamin D units per drop is supplied with each bottle.

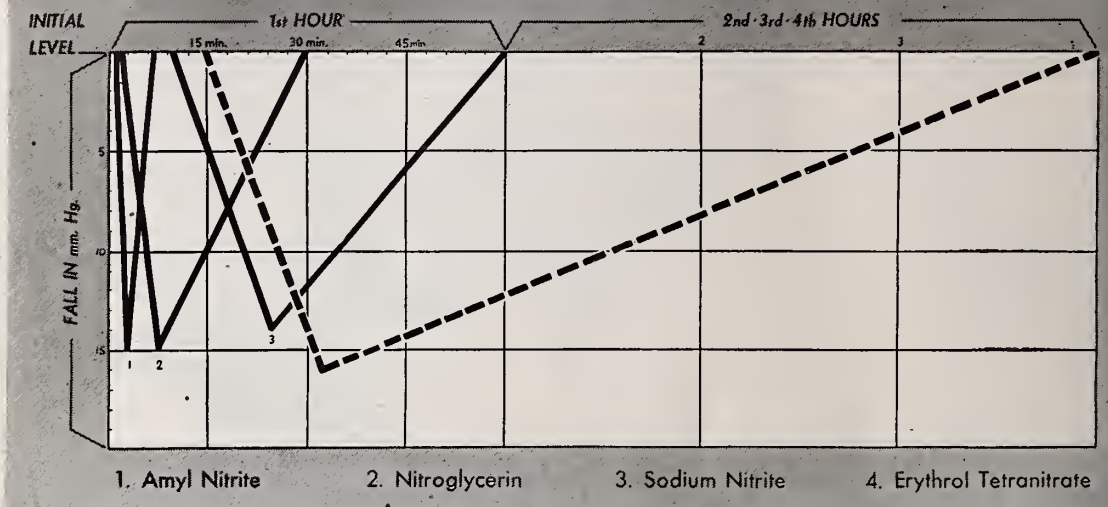
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Pharmaceuticals of merit for the physician WINDSOR, ONT.

**Drisdol** *in* **Propylene Glycol**

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# PROLONGED REDUCTION OF HIGH BLOOD PRESSURE




**Comparative effects of commonly used nitrites on systolic blood pressure in normal individuals. The action of Erythrol Tetranitrate Merck begins in 15 minutes and persists for three to four hours.**




Treatment of arterial hypertension today is necessarily directed toward relief and not cure. When such measures as rest and dietary control have been unsuccessful, the employment of medical treatment is suggested. Among the various preparations available, Erythrol Tetranitrate offers the advantage of producing a reduction in blood pressure sufficiently prolonged so that administration three times daily may maintain the reduction. Erythrol Tetranitrate Merck may be prescribed over a protracted period with sustained effect. By dilating the peripheral arterioles, it tends to decrease not only the stress of excessive pressure on the arterial walls, but also to relieve the burden of the heart.

**ERYTHROL TETRANITRATE MERCK**
(Erythrityl Tetranitrate)

**For Prolonged Vasodilatation in Hypertension**

COUNCIL ACCEPTED AMERICAN MEDICAL ASSN. ACCEPTED

**MERCK & CO., Inc.** *Manufacturing Chemists* **RAHWAY, N. J.**






*'Dexin' does make a difference*

COMPOSITION

| | |
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| Dextrins . . . . | 75% |
| Maltose . . . . | 24% |
| Mineral Ash . . . | 0.25% |
| Moisture . . . . | 0.75% |

Available carbohydrate 99%
115 calories per ounce
6 level packed tablespoonfuls equal 1 ounce

# *Progress report*

A mother has a deep sense of satisfaction when her baby is healthy and your progress report indicates that he is "doing well."

'Dexin' offers advantages that make it an important factor in the feeding of many babies. Its high dextrin content (1) provides a relatively low fermentable form of carbohydrate minimizing the possibility of distention, colic and diarrhea and (2) promotes the formation of soft, flocculent, easily-digested curds. Readily soluble in hot or cold milk.

'Dexin' Reg. Trademark

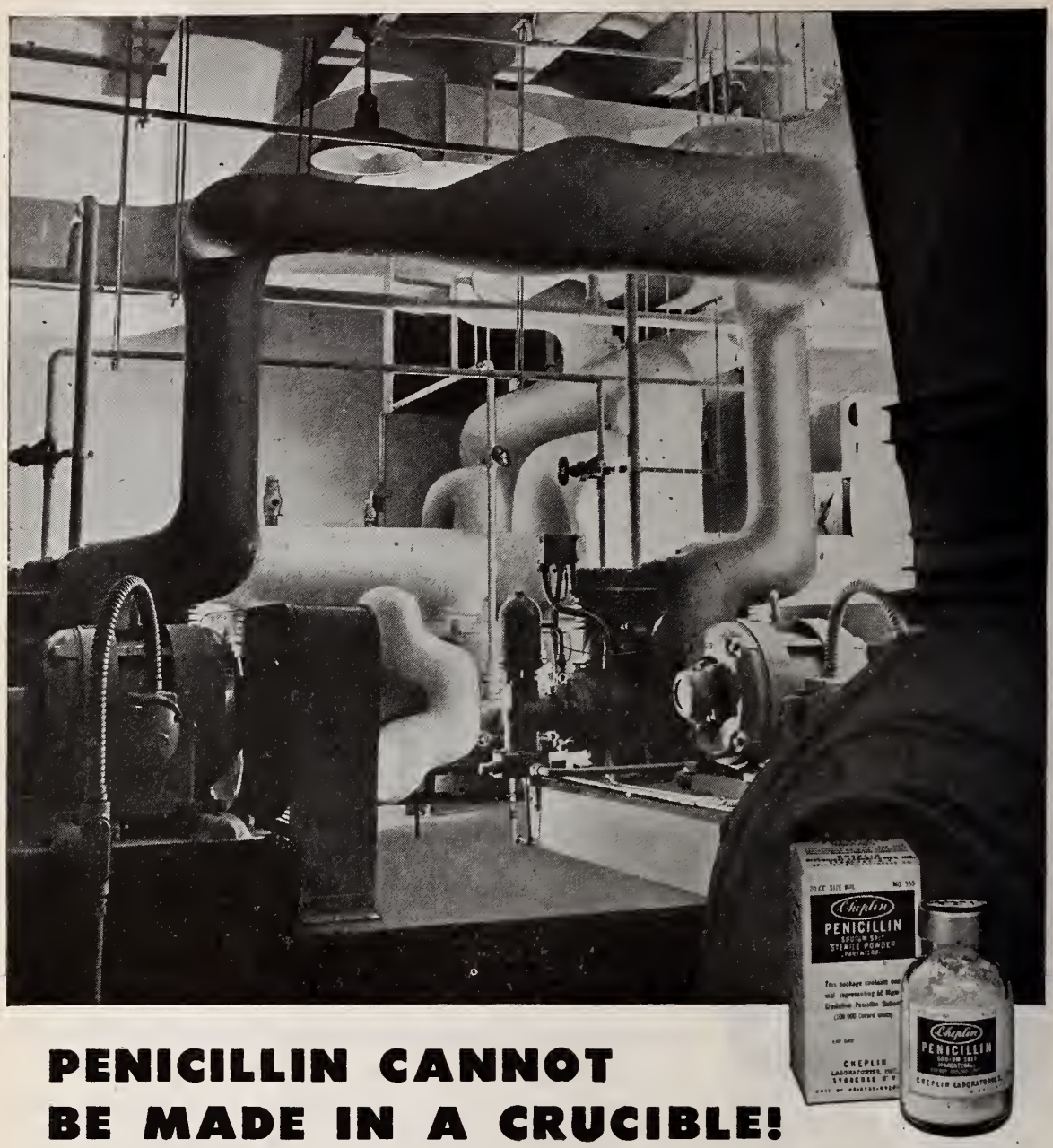
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*Literature on request*

'Dexin'

HIGH DEXTRIN CARBOHYDRATE

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# PENICILLIN CANNOT BE MADE IN A CRUCIBLE!

Bring back Paracelsus and his crucibles today...show him the clinical picture of Penicillin...take him on a trip through a great Penicillin plant like that of Cheplin Laboratories. What would he think? Your guess is as good as ours!

Just as strides in clinical medicine have been unmeasurable since Paracelsus' time, so too have been the strides in mass-manufacture and plant-investment. In the Cheplin plant at Syracuse, for instance, there are alone thirty miles of pipe needed to make this new "wonder-drug."

Who can state Medicine and the Pharmaceutical Manufacturer aren't working together for a better post-war world? And Cheplin is doing its bit!

**CHEPLIN**
**LABORATORIES INC.**
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**SYRACUSE • NEW YORK**

# BOMBING MISSION (medical version)




TARGET FOR TODAY...not Japs, but *rats*...mosquitoes...flies...disease-carrying insects and vermin that infest the steaming jungles of the Pacific.




For this is a *bombing mission in white!* The "bombs" are loaded not with T.N.T., but more likely with D.D.T. which, sprayed from the air, seeks out and kills the adult mosquito and fly.

Yes, with D.D.T., with the aerosol bomb and countless other new developments in sanitation and disease control, the soldiers of medical science are proving themselves fighting men through and through. And, like so many other fighting men, they find pleasure and cheer in a few moments relaxation with a cigarette. Probably a Camel for, according to actual sales records, Camels are the favorite with smokers in *all* the services.

**Camels** *Costlier Tobaccos*

R. J. Reynolds Tobacco Company, Winston-Salem, North Carolina

# IN WAR AS IN PEACE - - -

## HANGER ARTIFICIAL LIMBS RESTORE MEN TO LIVES OF ACTIVITY AND USEFULNESS



**Among those in the Armed Forces to whom Hanger Limbs have been supplied in recent months are:**

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**PERFECT FIT — COMFORT and PERFORMANCE**

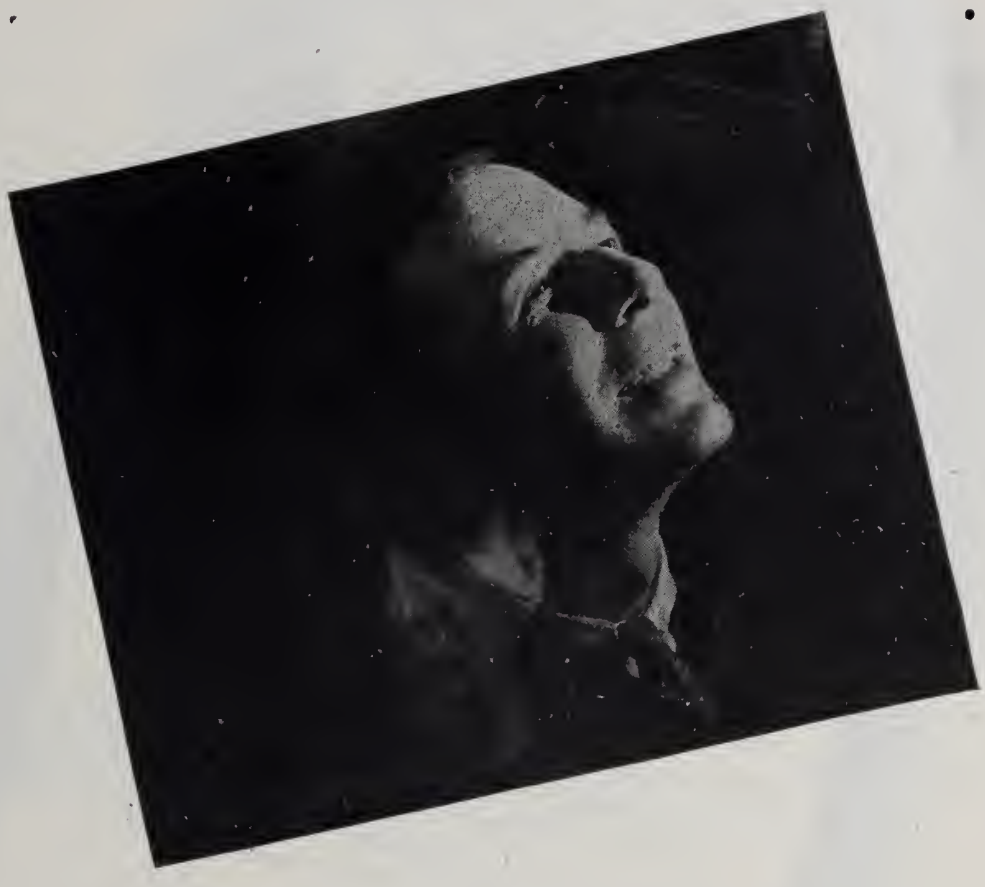
The result of over 80 years research,
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***"suddenly . . . life was worth living"****

In depressed patients, Benzedrine Sulfate is virtually unique in its ability to banish apathy, subjective weakness, and despondency . . . to restore mental alertness, enthusiasm and the capacity for work . . . to increase the sense of energy . . . and to reawaken the zest for living.



The quotation which heads this page provides, out of the author's own experience, striking testimony to the dramatic value of Benzedrine Sulfate in the relief of simple depression, with its associated symptoms of anhedonia, chronic fatigue and retardation.

*Reiter, P. J., Experience with Benzedrine, Ugeskr. f. laeger, 99:459-460, 1937.

**BENZEDRINE**
**SULFATE TABLETS**
Racemic amphetamine sulfate, S.K.F.

**SMITH, KLINE & FRENCH LABORATORIES, PHILADELPHIA, PA.**



# SANITIZE THE SKIN

**with the modern sulfated-oil cutaneous detergent, to avoid the possible aggravation of symptoms known to occur when soap is used.**

**PREFERRED BECAUSE**

★ it has the same physiologic pH as skin.

★ it contains high-molecular-weight fatty acids, known to be non-irritating.

★ it completely emulsifies skin soil, without lather, and being water-miscible, rinses off easily with any kind of water.

★ it is non-abrasive, non-alkaline, pigment and perfume free.




**INDICATIONS**

1. Detergent in dermatologic disease . . . 2. Detergent for soap-irritable skin . . . 3. Removal of excessive natural and residual medicinal oil and grease from skin, scalp, and hair . . . 4. Soapless surgical scrub-up . . . 5. Management of acne vulgaris.

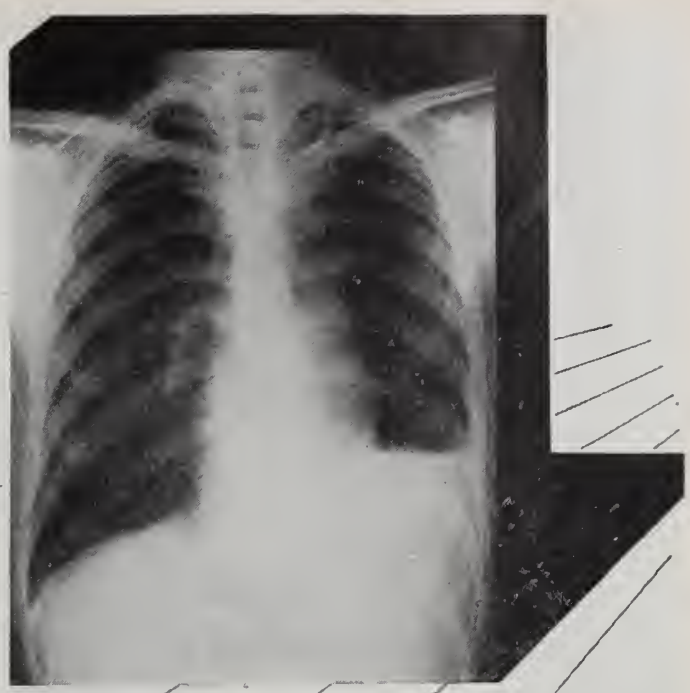
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# ACIDOLATE

**FOR CONDITIONS BENEFITED BY A SOAPLESS REGIMEN**



# PENICILLIN Creates New Concepts Sterilizing an Empyema

Penicillin shatters old concepts and is rapidly creating many new ones. This applies particularly to the treatment of empyema. It has been demonstrated that penicillin will usually sterilize the pleural exudate, provided the infecting organism is penicillin sensitive. A significant number of patients with pneumococcic, streptococcic, and staphylococcic empyema were improved or recovered after repeated aspiration of the pus and injection of penicillin.

Constantly expanding activities on the part of the Upjohn research laboratories and manufacturing staff are devoted to keeping The Upjohn Company in the forefront of penicillin developments. More and more penicillin is becoming available for civilian practice.

Penicillin (Upjohn) is supplied in vials containing 100,000 Oxford units.

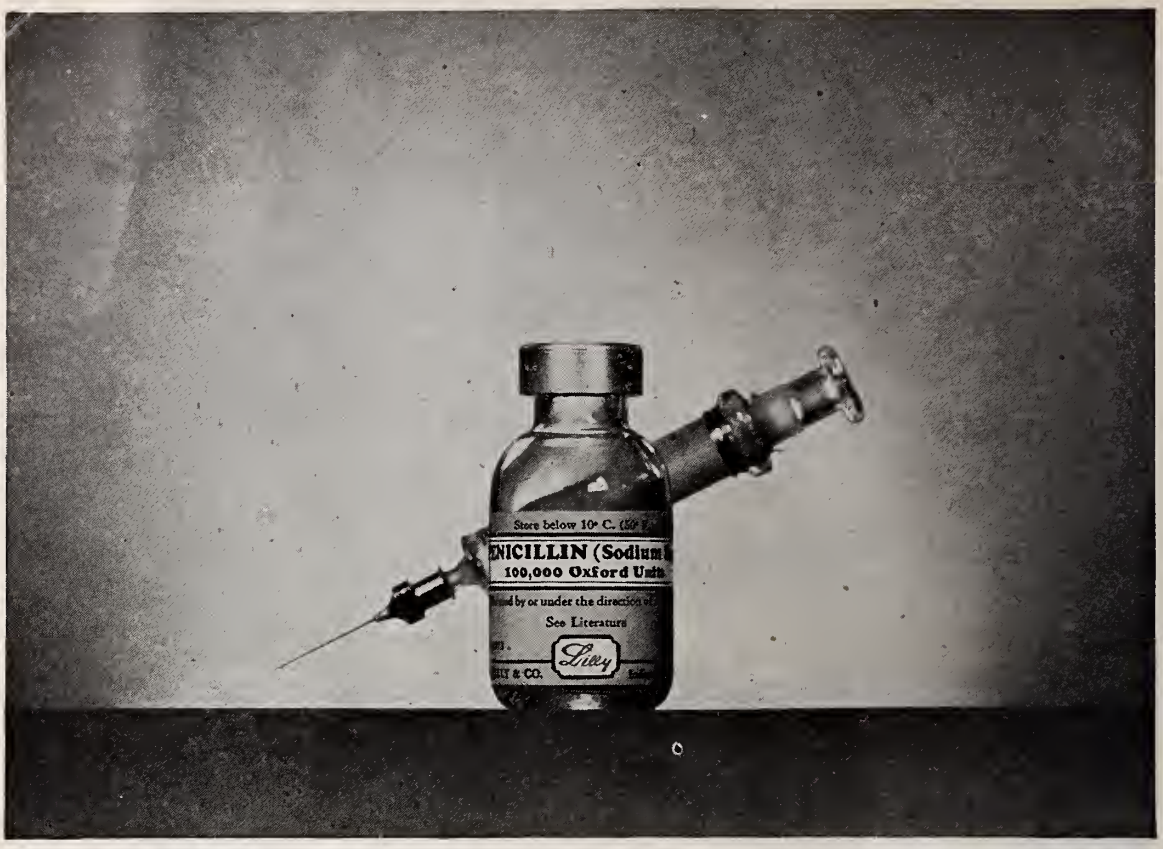
ARMY (E) NAVY

**Upjohn**

KALAMAZOO, MICHIGAN

*FINE PHARMACEUTICALS SINCE 1886*

DO MORE THAN BEFORE . . . BUY MORE WAR BONDS




# Penicillin...today's wonder drug

MORE PRECIOUS than the gold it resembles is the pinch of yellow dust in the bottom of a 20-cc., sterile, rubber-capped ampoule of Penicillin. This far-famed metabolic product of the lowly mold *Penicillium notatum* is a veteran performer of many miraculous cures. While the pharmaceutical industry was exhausting every resource to increase production of penicillin over and above the urgent needs of the armed forces, the drug was released for civilian use only in desperate cases, in many of which other treatment had failed. In this rigorous proving ground, penicillin has skyrocketed to fame.

The unique problems involved in the mass production of penicillin are rapidly being solved. The product has been purified to the point where it seldom causes side-effects or reactions. Safe, dependable, and pure, Penicillin, Lilly, represents a notable achievement in pharmaceutical excellence. Eli Lilly and Company, Indianapolis 6, Indiana, U.S.A.

Lilly

Volume 42
Number 2



# THE JOURNAL
OF
# THE MEDICAL SOCIETY OF NEW JERSEY

Published Monthly Since September, 1904
Whole Number of Issues, 486

Under the
Direction of the
Committee on Publication

Henry C. Barkhorn, M.D., Chairman

Henry A. Davidson, M.D., Editor
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**Editorial and Executive Offices of the Society—315 West State Street, Trenton 8, N. J.; Tel. 5776**
Each member of the State Society is entitled to receive a copy of The Journal every month.

Vol. 42, No. 2 | February, 1945 | Subscriptions, $3.00 per Year
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## EDITORIALS

### MESSAGE FROM THE PRESIDENT

THE NATIONAL PHYSICIANS COMMITTEE

At the meeting on January 21st, 1945, the Welfare Committee unanimously adopted resolutions approving the activities of the National Physicians Committee. These resolutions were then referred to the Board of Trustees with a recommendation for their approval.

The Board of Trustees met on January 28th, 1945, and unanimously approved the action of the Welfare Committee commending the activities of the National Physicians Committee.

I feel that a word or two from your President concerning these two actions are in order.

American medicine today is beset by many vexing problems and for their proper and adequate handling and adjustment, we must look to those in high places in our organized society for inspiration and leadership. For, surely, if they cannot, and, do not inspire hope and confidence in the rank and file—then, we are in a most pitiable plight.

The A. M. A. has formally approved the activities of the National Physicians Committee, and The Medical Society of New Jersey as an integral and virile unit of our great parent body should offer concrete proof of our confidence in this leadership and express our hope for its success. All complaints, or criticisms of the wisdom of the various actions, or principles of action of the A. M. A. which are, or may be in order, should and must come through the channels and sources of organized medicine. This is absolutely imperative if a united—forceful—articulate front is to be presented by medicine during this present crisis. This is an obvious truism. It needs no proof.

I therefore most heartily commend the National Physicians Committee—a group composed of men who have had many and various positions of distinction—

trust—and influence within organized medicine throughout the country.

They are actuated by motives which are well in conformity with the best traditions of American medicine. They are proceeding in an orderly and effective fashion—they have already accomplished much—and will accomplish more—and will eventually bring their labors to a happy fruition, only through the medium of the active, moral and financial support of the collective membership of our various State and County Societies.

JOSEPH F. LONDRIGAN, M.D.,
*President.*

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## IN MEMORIAM

### DR. WALT P. CONAWAY, FELLOW OF THE MEDICAL SOCIETY OF NEW JERSEY

It is with deep regret that we announce the death of Dr. Walt P. Conaway, on January 12, after a long illness. His passing breaks another link with the early days of Atlantic City and the middle twenties of The Medical Society of New Jersey.

Dr. Conaway established his practice in Atlantic City in 1901 and for more than forty years maintained his offices and residence at the corner of Indiana and Pacific Avenues, during which time he gained state-wide and nation-wide recognition in medical organizations.

Dr. Conaway was born at Leipsic, Delaware, June 17, 1873. His father was a member of the State Legislature. Like many outstanding men before him, after completing his preliminary education in the public schools, he taught school in his native state in order to earn money for tuition in college; and in 1894 graduated from Delaware College with a degree of A.B. Four years later he received his M.D. from the University of Pennsylvania, continuing his medical education with a post-graduate course in surgery, for one year, at New York University. During the summers of 1899 and 1900 he was assistant to the late Dr. Philip Marvel, who is still remembered as one of the foremost physicians of his time in Atlantic City.

In 1901 Dr. Conaway was appointed to the Staff of the Atlantic City Hospital, which at that time was small both as a Staff and as an institution, and served the hospital faithfully during the succeeding forty years of its growth.

Dr. Conaway held membership in the County and State Medical Societies and in 1927 was President of The Medical Society of New Jersey. During his presidency he attended at least one meeting of each component County Society. This was appreciated both because of his good fellowship and because of his sincere interest in the problems of all sections of the state.

He vigorously forwarded the anti-diphtheria campaign which has produced such marvelous results in the ensuing years and constantly advocated periodic health examinations. He was a great factor in the 1928 revision of the Constitution and By-Laws which did away with the Permanent Delegates and established a more democratic procedure; it also separated the work of the House of Delegates from the Scientific Sessions.

He was among the first to suggest that the First Vice-President be the President-Elect so that this officer would have more opportunity for active participation in the work of our State Society.

He also served a term as First Vice-President of the American Medical Association and as President of the Society of Surgeons of New Jersey. Other memberships in medical organizations were: New York Academy of Medicine; New

York Obstetrical Society; Philadelphia Pathological Society; Philadelphia Obstetrical Society, and the Philadelphia Medical Club. In the latter he had the distinction of being the only non-Philadelphian elected to the office of President, which honor was accorded in 1942.

Doctor Conaway came to Atlantic City in the days when it was beginning to outgrow its fishing village status, to emerge into its present important place in the nation. He had the stature to grow in skill and personal recognition with the city of his adoption and will long be remembered for the part he contributed.

## PUBLIC RELATIONS TOWARD NATIONAL SICKNESS INSURANCE

On January 3, 1945, Mr. Dingell introduced H. R. 395 in the House of Representatives. It is identical with the Wagner-Murray-Dingell Bill of 1944. Just what Mr. Dingell's strategy may be is not clear. It does indicate the persistent line of thought occupying the mind of Mr. Dingell and the minds of his supporters.

H. R. 1442 was introduced in the House on January 3, 1945, by Representative A. L. Miller, a physician member of the House from Nebraska. This Bill is limited to provisions for medical care and hospitalization costs for persons eligible for old age assistance.

On January 11th Dr. Miller introduced H. R. 1391, which provides for a Department of National Health with a Secretary of Cabinet rank. For over fifty years the organization of such a Department has been one of the objectives of American Medicine.

These are the first of several Bills we may anticipate will be introduced during the 79th Congress, the merits and detrimental features of which must be determined and evaluated by the profession.

We know, whether we are all willing to admit it or not, that there will be a new national economy after this war, and that there are bound to be changes in our existing social order. It is only day dreaming to conclude that medicine will not be seriously involved in these changes. How can we, as individual physicians, express to patients and other contacts the basic beliefs, philosophy and objectives of the medical profession in guiding public opinion concerning these matters?

In dealing with people in general we can admit the existence of the problem, and agree with them in the social objective that economic security and adequate medical care should be available to all people. We, of all men, know the value of good health. We know it is necessary to clear thinking, and constructive effort of the individual, in finding his place under this new national economy and altered social order. It has been made clear by public opinion that our function during the evolution of this new economy will be to develop a condition of national health which will enable the maximum number of people to carry on a creative, constructive life by which they can provide for their welfare and otherwise fulfill their obligations as citizens in their communities. We do not object to medical care of the indigent and medically indigent being provided through tax funds and are willing to contribute our share of taxes to provide this care. We want to see these things accomplished for the benefit of self-supporting persons, but not through any socialistic, paternalistic or wet nursing program. We want it accomplished on a sound basis; a program of private enterprise under which all self-supporting persons have an opportunity to determine their own destiny and produce their own security through their own effort and labor.

. In dealing with those who are supporters of a national sickness insurance program it is useless to present arguments based upon the dangers of regimenting the medical profession, or based upon dangers to the future welfare of medicine. We have never noted a tear being shed, not even a moist eye or expression of sympathy, among any such lay audience before whom such a plea was presented. They are not interested in the future welfare of the medical profession as a whole, and consider it none of their business. They want more adequate medical care at more nominal cost, period; and they believe it obtainable through a national program. But, they are interested in the welfare of their own individual physician. They want to be able to approach him as an individual and be treated by him as an individual, and have his services adequately paid for. They are interested in protecting their own interests and they believe in the principles and traditions of democracy. Therefore, the individual physician has a job to do.

It should be explained to these people that such a movement as national sickness insurance is a leftist movement and a dangerous precedent away from democracy, under which they may unwittingly lead us to a situation under which the individual becomes subservient to the State instead of the State remaining a servant of the people. It should be explained that our democratic government is established on a community and state basis, with a federal government intended to be only a central coördinating agency of government at lower levels. Any deviation from this traditional system of government is in our opinion leftist in character. Only when our various socio-economic and geographical groups fail to reconcile their opinions and solve their problems among themselves or with community governments is it proper to refer these problems to the next higher echelon of government. It is only by reference of these problems to higher echelons of government that we develop a centralized, bureaucratic, form of government controlling the activities of individuals, and such control is not consistent with democracy. Any effort they may make to solve their own problem, or any assistance they may be to the medical profession in solving the medical care problem is an evidence of practical democracy. No magic or governmental panacea can replace coöperation, personal initiative and effort among interested groups at a local level in solving any of our problems. An argument on such a basis, together with assurance that the profession will make available to them the type of service and assistance that will enable them to provide their own security against the cost of medical care, will frequently guide their opinion in our favor. However, they must be made to understand that this accomplishment by the medical profession must be based upon the greatest of all teachers, old man experience, and that the medical profession is experimenting with plans which will lead to a proper solution of their problem.

Every physician should have on hand and be acquainted with the "Platform of the American Medical Association". This platform states in clear, concise words the policies and objectives of the medical profession upon which a proper solution of the problem can be developed. It is consistent with the beliefs of the vast majority of physicians and should be adopted by each individual physician for the sake of unity and in guiding public opinion, particularly among the groups who now believe in national sickness insurance.

Another group we must watch is the employer group. Under any economic system it is the profits of industry which support the people. As we approach the new post-war social era it becomes more and more evident that the employer will be called upon to make better provisions for the economic and social welfare of his employees and their dependents. He,

above all men, from his recent experiences, appreciates the value of independence and freedom from bureaucratic control. It should not be difficult for the individual physician to convince his employer friends of the desirability of making a voluntary contribution to the support of an insurance program to assure more adequate medical care of his employees. It should appear to him as the democratic alternative to bureaucratic control, and as a means of establishing a more solid human relationship with his employees.

By and by the lights of the world will go on again, and when that day comes the light reflected by the medical profession may largely depend upon the public relations effort exerted by the individual physician during the next critical months. We hope the above suggestions will help the individual physician, for it is he who can do the best job in guiding public opinion.

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## MEDICAL-SURGICAL PLAN OF NEW JERSEY

### Experience from Jan. 1-Dec. 31, 1944

The following is presented to depict the experience of Medical-Surgical Plan for the year 1944. We believe it reflects the soundness of the Plan as part of the program of the Society to improve medical care distribution.

The total enrollment for the year is a little larger than the 1000 additional per month we anticipated enrolling during this experimental period, but not sufficiently greater to affect materially the income of the profession.

| | |
|---|---|
| Enrollment as of Dec. 31, 1944 | 30,427 persons |
| Average Number of Persons During 12 Months | 24,302 " |
| Enrollment as of Dec. 31, 1943 | 16,015 " |

| | 1944 | | 1943 | |
|---|---|---|---|---|
| Earned Income | $187,708.74 | (100 %) | $74,498.17 | (100 %) |
| Claim Costs | 135,605.75 | ( 72.2%) | 49,562.50 | ( 66.5%) |
| Operating Expenses | 35,504.03 | ( 18.9%) | 17,785.96 | ( 23.9%) |
| Earned Reserves | 16,598.96 | ( 8.9%) | 7,150.01 | ( 9.6%) |
| Total Reserves | 28,800.31 | | 12,201.35 | |
| Annual Hospital Admission Rate per 1000 | 91 | | 71 | |
| Average Cost per Claim | $61.22 | | $67.07 | |

Our operating costs have been reduced by five per cent of income as compared to last year. All operating costs for the year have been paid except for the cost of a routine examination by the New Jersey Department of Banking and Insurance which will cost us about $1,100.

Our annual admission rate of 91 per 1000 compares to a rate of 77 among the general population of New Jersey, indicating that we are reaching that class of person who would not have entered hospital for treatment under other conditions because of costs.

The total reserve of $28,800 includes the $5000 advanced to the Plan for organizational purposes by The Medical Society of New Jersey.

# ORIGINAL ARTICLES

## PURPURA ANNULARIS TELANGIECTODES
### (WITH REPORT OF AN EARLY CASE)

EMANUEL M. SATULSKY,* Major, Medical Corps †

In 1896, Majocchi [1] described an unusual disease of the skin. He had observed three cases of a similar nature characterized by the formation of minute telangiectatic macules or puncta which tended to form annular lesions of various sizes. These lesions disappeared in varying periods of time, with or without atrophy.

MacKee [2] in 1915 completely reviewed the literature of 38 cases in all, including the original 13 cases described by Majocchi, and one of his own. He described in detail three fairly well defined clinical phases: telangiectasis, hemorrhage (purpura) and pigmentation, and atrophy.

Among the more recent authors to describe and investigate this rare type of purpura are: Semon, 1920;[3] Balzer, 1926;[4] Majocchi, 1928;[5] Scholtz, 1929;[6] Way, 1930;[7] Levin and Tolmach, 1933;[8] Way, 1936;[9] Degos and Meyer, 1938.[10]

Report of a case:

R. H. L., a 19-year-old white soldier, was born in Chicago, Illinois, and had lived there all his life. His mother, father and one sister are living and well. There is no history of tuberculosis, cardiovascular-renal disease, diabetes or blood dyscrasia in his family.

The patient had the usual diseases of childhood, including varicella, measles, whooping cough and mumps. In July, 1942, he had an attack of fever which lasted one week, the cause of which could not be determined.

At the time of the first admission to this hospital he had been in the army for eight months; five months of this time were spent in the tropics. In civilian life he worked in a mill as a band-saw operator. He denied any venereal diseases.

About 10 days prior to his admission on December 14, 1942, he began to have difficulty in breathing through the right side of his nose. He had fallen while exercising in a gymnasium and had struck his face on the floor. Following this accident he noticed a definite deformity of the nose. Prior to this he had experienced no difficulty or interference with nasal breathing. The diagnosis of "Nasal obstruction, right, with a deviated nasal septum" was made, and on December 17, 1942, a submucous resection was done. Local anesthesia with cocaine and novocaine was used. His recovery was uneventful and he was discharged to duty 10 days later, on December 27, 1942.

At the time of admission for this operation, his physical examination findings were all normal. Blood pressure 110/70. Hemogram showed: erythrocytes 4,400,000; leucocytes 4,600; differential count showed polymorphonuclears 52%, lymphocytes 46%, and eosinophiles 2%. Hemoglobin 85% (Sahli). Clotting time 5′ 30″. Bleeding time 2′. Urinalysis showed normal findings.

During the last four days of his hospitalization he noticed a "few tiny red spots" on the medial aspect of the left leg in the lower one-third. There were no subjective symptoms and he did not report the lesions to the medical officer. Several days after leaving the hospital, these areas began to enlarge and many new lesions appeared on the right leg and foot, the thighs and the forearms. He reported on sick-call and was readmitted to this hospital on January 18, 1943.

#### PHYSICAL EXAMINATION

Patient is a 19-year-old white male soldier, well developed, intelligent, alert and very coöperative. Weight: 185 pounds. Height: 6′ 4″. His only complaint was occasional itching of the lesions on the legs and feet. The eye-grounds were normal and showed no signs of hemorrhage or exudate. The tonsils were moderately enlarged but did not appear infected. There were no clinical evidences of avitaminosis or of other constitutional disturbances. Blood pressure: 122/72. The spleen was not palpable. There were no signs of tuberculosis or of hereditary syphilis. There were no neurotic tendencies, although he was upset for several days after receiving word that his mother and father were separating. The conjunctivae were clear; the nail beds showed no hemorrhage; there was no rectal bleeding; the gums were firm and pink.

* Chief of Department of Dermatology and Syphilology, 210th General Hospital.
† Medical Corps, Army of the United States.

1. Majocchi, D.: Gior. ital. d. mal. ven., 31:242, 1896.
2. MacKee, G. M.: J. Cutan. Dis., 33:129, 1915.
3. Semon, H. C.: Proc. Roy. Soc. Med., 14:8, 1920.
4. Balzer, F.: Ann. de dermat. et syph., 7:529, (Oct.) 1926.
5. Majocchi, D.: Arch. ital. di dermat. sif., 3:433, (June) 1928.
6. Scholtz, M.: Arch. Dermat. and Syph., 19:769, (May) 1929.
7. Way, S. C.: Arch. Dermat. and Syph., 21:42, (Jan.) 1930.
8. Levin, O. L., and Tolmach, J. A.: Arch. Dermat. and Syph., 1933, xxviii.
9. Way, S. C.: Arch. Dermat. and Syph., 34:605, 1936.
10. Degos, R., and Meyer, A.: Bull. Soc. franc. de dermat. et syph., Feb. 1938.

### DESCRIPTION OF THE ERUPTION

The eruption was located on the various surfaces of the thighs, legs (see illustration), dorsi of the feet and the flexor aspects of the forearms. The mucous membranes and other parts of the body were not involved.

The earliest lesions were minute, discrete, bright red, punctate macules varying in size from a pin point to that of a pin head. They were not limited to the hair follicles, and although some of them did occur, there was no elevation. On diascopic pressure, although a paling did occur, they did not disappear and there was no appreciable change in the color. There was no ecchymosis present. The lesions enlarged by peripheral extension to a diameter of from 1-2½ centimeters. As they enlarged, the centers cleared and a brownish-yellow pigment remained. In some areas, particularly on the legs and thighs, some of these annular lesions coalesced and formed circinate and arcuate patches. The borders of the lesions were erythematous and contained innumerable tiny, dark-red telangiectatic puncta. These were best seen when the epidermis was stretched and the areas examined through a lens. Some of the older lesions about the ankles and on the dorsi of the feet showed a fine white furfuraceous scaling. The older and terminal lesions were pale brownish-yellow in color and faded gradually; they left no detectable atrophy.

### LABORATORY FINDINGS

Radiographic examination of the heart, great vessels and lungs showed normal findings.

Two Kahn and Wassermann tests of the blood were negative.

On one occasion a trace of occult blood was found in the stool after three meatless days. This could not be repeated. Hemograms showed:

| | | | |
|---|---|---|---|
| Erythrocytes | 4,530,000 | 4,400,000 | 4,400,000 |
| W.B.C. | 6,100 | 6,400 | 4,300 |
| Polymorphonuclear leucocytes | 50% | 50% | 64% |
| Lymphocytes | 50% | 50% | 36% |
| Hemoglobin content (Sahli) | 85% | 85% | 85% |
| Bleeding time | 2 min. | 1½ min. | 3 min. |
| Clotting time | 4 min. | 4½ min. | 5 min. |
| Platelets | 210,000 | 200,000 | 220,000 |

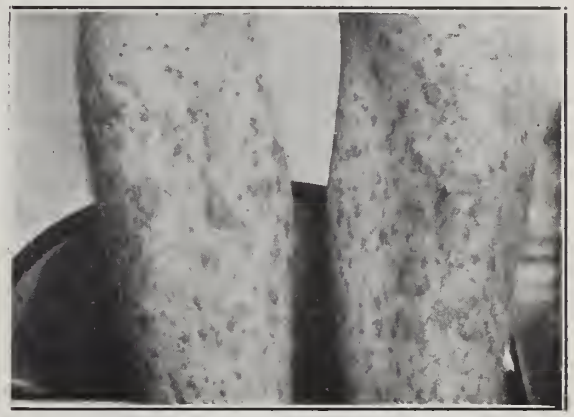
The tourniquet test: No capillary fragility was noted in 15 minutes with the blood pressure cuff held mid-way between the systolic and diastolic readings.

Urinalysis revealed clear, amber-colored urine; Sp. Gr. 1.021; no sugar or albumin; acid reactions; negative microscopic findings.

### PATHOLOGY

Two specimens of skin were removed under local anesthesia with 2% Novocaine. Specimen No. 1, an older lesion, from the left thigh; specimen No. 2, a newer lesion, from the right thigh. These specimens were sectioned and stained at this hospital.

Both sections were essentially similar under high and lower power studies. There was a slight degree of parakeratosis present. The basement membrane was intact. In the mid and upper cutis were a number of dilated and congested capillaries and smaller arterioles with more marked telangiectasia of the subpapillary capillaries. The upper layers of the cutis were edematous and there was a distinct increase in the number of capillaries. In the upper and mid cutis were scattered small collections of free erythrocytes. There were foci of lymphocytes, plasma cells and some endothelial cells, some of which were perivascular. The sebaceous glands showed no alterations. Some of the vessel walls showed a suggestion of hyalin degeneration. The elastic fibres were apparently normal. No tubercle bacilli could be found after repeated examinations.



Clinical Lesions of the Legs

In favor of the diagnosis of Majocchi's disease is the vascular disease limited to the mid and upper cutis, some telangiectasia, definite hemorrhage and only a suggestion of hyalin degeneration of the vessel walls. To make an absolute diagnosis one would like to find aneurysm of these vessels, more definite hyalinization of the vessel walls and less cellular infiltration. However, this is a long-standing vascular disease of the small vessels and the pathological findings fit in with the diagnosis in its early stages.[11]

MacKee,[2] in his comprehensive study, found the following pathological changes in an early case: endarteritis with an increase in the number of small capillaries; edema in the corium; hyalin degeneration of the arterial walls; aneurysmal sacculation in some places; areas of hemorrhage in the corium, and in addition, a moderate amount of perivascular infiltrate.

11. Sachs, Wilbert: Personal communication to the author.

## COMMENT

This disease usually attacks young males; MacKee [2] found three times as many males were affected as females.

Majocchi [1, 5] has stated that the etiology is obscure but that the disease is probably a vasomotor phenomenon having some resemblance to erythema pernio. Way [7] concluded that the microscopic changes suggest that the disease is due to a toxin. In his detailed studies acid-fast bacilli were found, but doubt of their being the bacilli of Koch existed. Some of his sections showed Russell-fuchsin bodies which were of doubtful significance. In 1933, Levin and Tolmach,[8] after a careful study, concluded that this disease is a cutaneous manifestation of a general cardiovascular process. Way [9] has also stated that as one investigates the pathological picture, local causes can be excluded and that the toxic theory advocated by Majocchi and other investigators deserves attention. The earliest pathologic change, i. e., capillary dilatation, suggests a toxic etiology. In the corium, the vascular dilatation, the endarteritis, the edema of the upper and midcutis, and the infiltration of lymphocytes are all substantiating factors of this theory.

According to Majocchi, this disease (Telangiectasia follicularis annulata) should have the following clinical characteristics: rose-colored or livid spots from capillary dilatation, followed by hemorrhage; no previous hyperemia or any infiltration of the skin; lesions usually in connection with the hair follicles; slow development and gradual increase in size; constant growth of the lesions resulting in annular, circinate and ring forms; symmetrical distribution on the extremities; primary location on the extremities, usually the lower; usually no subjective symptoms; resulting atrophy, achromia and alopecia in most cases.

From these characteristics it is seen that the clinical features in this case agree and coincide with Majocchi's description, except in the following points: predominant limitation to the hair follicles and the resultant atrophy, achromia and alopecia. My findings agree with those of other observers who have stated that the follicular involvement is not a characteristic clinical finding in this disease. Way,[7, 9] in observations on his reported cases, noted no atrophy, achromia or alopecia. These findings agree with those I have made in this case.

During hospitalization, repeated searches were made for foci of infection. The patient was kept in bed and the lower extremities were elevated. As part of empirical therapy, he was given cod-liver oil, calcium gluconate and large doses of multiple vitamins by mouth. He has been seen at weekly intervals for four months; careful examinations microscopically through a lens have revealed no atrophic changes in his skin at the sites of the lesions, and no new lesions have appeared. There has been no loss of hair and no alterations in pigment. The lesions have gradually faded (without therapy), and except for a faint brown-yellowish discoloration, have entirely disappeared.

## SUMMARY

1. A case of Purpura Annularis Telangiectodes (Majocchi) is reported.

2. The clinical and microscopic features in this case, except for two minor variations, are those accepted as diagnostic of this disease.

3. From microscopic study, the theory of a toxic origin seems most acceptable.

4. No tubercle bacilli were found.

5. This case showed no predilection for hair follicles and no atrophy, achromia or alopecia could be found.

The author is indebted to Captain M. J. Robin, M.C., for his aid in obtaining the clinical photograph.

Elizabeth, N. J.

# PENICILLIN SODIUM IN THE TREATMENT OF SULFONAMIDE-RESISTANT GONORRHEA *

JOHN F. JUDGE, Captain, M.C., Camp Kilmer, N. J.

A supply of penicillin was first made available to the Station Hospital, Camp Kilmer, N. J., in October, 1943, to be used for personnel being staged for overseas service. This report deals with the results obtained with penicillin in eighty patients hospitalized for the treatment of sulfonamide-resistant gonorrhea.

## TYPE OF CASES

All patients in this series had failed to respond to two or more courses of sulfonamides. Every patient had a minimum of 34 grams of a sulfonamide drug over a five to twelve-day period. Some had had as high as 120 grams over a six-month period.

The average duration of the disease before penicillin therapy was 15 to 20 days.

The diagnosis of gonorrhea was established in each case by urethral smear and culture studies. All were positive for the gonococcus.

## THERAPY

The penicillin therapy covered a period of ten hours. It consisted of an intramuscular injection into the gluteal muscle of 10,000 Oxford units every hour for ten hours. The drug was prepared separately for each case and used immediately. Distilled water was used as the solvent. No other form of treatment was used concurrently.

## RESULTS

Since it was imperative that the patients treated proceed with their respective units, the follow-up period of observation in 90 per cent of our cases has not been sufficiently long to justify *unqualified* conclusions. The observation period in 90 per cent of the cases was three days. On each of these days we obtained a negative smear and culture for the gonococcus. The remaining 10 per cent were observed for as long as three weeks. All so observed were clinically and bacteriologically negative at the end of this time. Based on this limited period of observation *79 of the 80 patients obtained an apparent cure from a clinical and bacteriological standpoint.* The only failure in this series was cured with a second course of penicillin given in the same manner. This case after his first course showed no improvement from a clinical or a bacteriological basis. Three days following his initial course of penicillin treatment he developed an acute epididymitis. He was then given a second course of penicillin and within 24 hours the acute process had subsided and clinical improvement was *marked.* Smears and cultures were reported negative after 24 hours, and remained so for three weeks while under observation. It is our impression that this failure was due to the use of an inactive drug because his response was so dramatic to the same number of units given a second time.

## TOXIC EFFECTS

*One* (1) case the day following treatment developed a mild, generalized urticaria. *Four* (4) other cases complained of headache, severe enough to warrant medication, after 4 or 5 injections of the drug had been administered. These were the only effects noted and these were indeed of a minor nature.

## SUMMARY AND CONCLUSIONS

1. Eighty patients with sulfonamide-resistant gonorrhea were treated with penicillin, 100,000 units, administered intramuscularly in 10,000-unit doses every hour for ten hours. Seventy-nine were considered "cured" and the single failure responded successfully to a second course.

2. Penicillin is our most potent weapon against sulfonamide-resistant gonorrhea and should replace the sulfonamides in the treatment of this disease. It reduces hospitalization and days lost from duty to a minimum.

* These cases were under the control and supervision of the G.-U. Section, Station Hospital, Camp Kilmer, N. J., Major N. Kutzman, Chief of Section.

# BRIEF PSYCHOTHERAPY: REPORT OF A CASE

ELSWORTH F. BAKER, M.D., Marlboro, N. J.

The term, brief psychotherapy, denotes technical procedures of a palliative character. The aim is to relieve the patient from certain symptoms that are painful or dangerous, or to aid him in handling a given situation or problem. Deeper changes in the personality are neither attempted or possible. Instead of reforming from within, we do more supporting from without. This limited goal must be achieved in a limited number of well-timed interviews. Brief psychotherapy is, therefore, not an abbreviated form of the standard type of psychoanalytic treatment. It has different objectives, points of attacks, indications, and conditions of administration. In psychoanalysis, the aim is to raise the patient's operational efficiency by re-adaptation on the largest possible scale and the patient must have considerable mental flexibility and be in a position to spend a great deal of time and money.

This patient was referred by a physician who recognized the psychogenic elements in her symptoms. Mrs. M. F., a married, white female, age forty-six, of native birth and parentage, complained of severe migraine headaches which she had had for the past twenty years. During the previous two years she had added the symptoms of insomnia, discomfort in the back of her neck, radiating to the scapular region, palpitation of the heart, general malaise, depression, and increasing concern about possible hardening of her arteries. She had received treatment for her migraine headaches over a period of years and from a number of physicians who had employed all the usual therapeutic measures, including ergotrate and histamine, without benefit.

Examination showed her to be a well poised, intelligent woman, who was obviously quite distraught concerning her symptoms. Her early history was inconsequential. She had an eighth grade education and had studied music extensively, including the pipe organ, and had been prominent in church work. She was married in 1918 during the war to a man five years her senior who was already in the armed forces. She lived with him but one month when he was forced to go overseas. Following his return in 1919, their married life was satisfactory for a period of one month. Since then she felt that they had not been compatible, she lost sexual interest, and consistently avoided relationships. She, however, became pregnant and has a daughter, nineteen years of age. She believes that her husband has continued fond of her in his way, although he is emotionally quite unstable. At one time they did separate for a period of six months. She returned to him at his insistence after he had threatened suicide and made numerous other threats in order to persuade her to return. She has considered divorce, but has been afraid because of her husband's possible suicide.

Because of her rigid moral attitude and strong religious leanings the examiner was loathe to delve deeper into her sexual history, but for the sake of being thorough she was questioned concerning premarital and extramarital experiences. She denied the former, but when asked concerning extra-marital affairs she rather surprisingly admitted that for the past fifteen years she had carried on an affair with a married man, seeing him as frequently as opportunities would allow. With him, her sexual adjustment had been highly satisfactory, enjoying the sexual act, and obtaining an orgasm almost each time. They were companionable, liked the same things, and had discussed the possibility of each obtaining a divorce and marrying, but he had put it off from year to year, maintaining that it would interfere with his career should he have the publicity of a scandal. She, in turn, hesitated because of her daughter and her husband's threats. She admitted that the whole affair had been a tremendous mental strain and she was at a loss as to a solution. It is of note that her headaches had been present prior to her affair, but commenced shortly after her husband's return from France. Her other symptoms had developed gradually over the past two years. Her history was otherwise

negative except for a few menopausal symptoms which had been already relieved by theelin.

Her situation was discussed with her over a period of three sessions, and the necessity of facing her problems frankly and solving them was stressed. To continue in her present situation was indeed sufficient to give her "a headache and a pain in the neck", not to mention the train of other disturbing sensations. By her own confession she did not love her husband and had planned several times to leave him and she was willing to doubt the sincerity of her own and her paramour's love for each other; otherwise, one or the other would have insisted on some action many years before. Certainly divorce would have created no more scandal than they were risking at present.

She was advised to leave her home for a trial period and to communicate neither with her husband nor her friend, and to report by letter to the author after a period of six weeks. This she did and reported that she had found a position some distance away and that although her symptoms had persisted for a week or two, at the present time she was making a good adjustment, was sleeping well, no longer felt nervous, and her headaches and other symptoms had disappeared. Nothing was heard from her for a period of one year when she again consulted the author with a recurrence of all of her symptoms. It was ascertained that her friend had located her whereabouts, had gone to her, and persuaded her to return home, and at the present time they were carrying on the same relationship as formerly.

The return of her symptoms following her return to her old situation was quite significant and when pointed out was obvious to her. At her suggestion she was seen with her friend and their situation discussed at length. They were told that neither had any claim on the other in their present situation and that they were at liberty to make any plans they pleased. Since the friend was not being treated, no advice was given to him, but because of the patient's symptoms it was necessary that she take some action and make some changes. She decided to obtain a divorce, but was carefully instructed that she should not do so merely in the hope of marrying her friend. If she felt that she would obtain one, regardless of his action, then it did seem a logical procedure. Some weeks later she reported from a distant state where she was residing in order to obtain a divorce that her symptoms had again cleared. She was happy in her decision and was going to make her own future. Three months later she again consulted the examiner with the statement that she had obtained her divorce from her husband, had returned to her community, and although she had had no return of her symptoms she had become quite upset and depressed because her friend had apparently lost interest in her, and at her age she was concerned about her future. She was reminded of the advice already given to her and it was suggested that as long as she was married this other man felt safe in going out with her, but now that she was free to marry him he was losing interest; that it would be better if she made up her mind once and for all to give him up. She could occupy herself with social activities and take up some form of welfare work where she could feel that her life was worthwhile. She was reminded that there were still many unattached men she could interest herself in. She brightened considerably and asked the author if he knew any. She was instructed to find them for herself.

Several months have elapsed and her reports have been consistently good, although there has not been sufficient time to decide whether permanent cure has been effected. Extensive psychotherapy was not felt advisable in this case and the length of time required to delve into deeper problems would have been prohibitive. The concern was, therefore, to solve her major present problems and allow her to adjust to a more satisfactory life. The significance of many of her symptoms was illustrated, but these points are omitted as not being necessary to illustrate this case. For example, her concern over arteriosclerosis was found to be due to the fact that her mother had died in a mental hospital from cerebral arteriosclerosis and the significance was that she felt her situation was driving her insane.

This case illustrates the benefit that can sometimes be obtained through brief psychotherapy, but it is also noteworthy that the coöperation of the patient is required and that she have the ability and willingness to make the changes necessary in solving disturbing problems. Usually, the fact that the individual comes for help means that she is prepared to make the necessary changes. For this reason, one who comes voluntarily usually has a much better prognosis than one who is persuaded to come by relatives or her physician.

## WITH NEW JERSEY MEDICAL AUTHORS

Compiled by MILDRED V. NAYLOR, Librarian, Academy of Medicine of Northern New Jersey

It is requested that any New Jersey physician who publishes an article outside the state, notify the Editorial Office in Trenton, giving the title of the paper and the name of the periodical, as well as the month, date, volume and page number. It would also be helpful to this office if members would notify us of articles published by their colleagues.

BRAUNSTEIN, WILLIAM P.—see Ginsberg, George

BUGIE, E.—see Waksman, Selman A.

CARPENTER, C. C.—Summit (in service), with others
Recurrent vesicular eruptions appearing during administration of penicillin. Arch. Derm. & Syph. 50: 6-7, July '44

CONN, JEAN R.—see Geiger, Walton B.

COWAN, HENRY—see Usher, Glenn

EISENSTODT, L. W.—Newark
Surgical treatment of atrophic rhinitis. Arch. Otolaryng. 40: 451-456, Dec. '44

GEIGER, WALTON B.; JEAN R. CONN and SELMAN A. WAKSMAN—New Brunswick, New Jersey Agricultural Experiment Station
Chaetomin, a new antibiotic substance produced by chaetomium cochliodes. II. Isolation and concentration. J. Bact. 48: 531-536, Nov. '44

GINSBERG, GEORGE, and WILLIAM P. BRAUNSTEIN—Hoboken
Acute septicemia with adrenal hemorrhage (Waterhouse-Friderichsen syndrome); a report of four cases with two recoveries. J. M. Soc. New Jersey 42: 7-10, Jan. '45

HAMRE, DOROTHY—see Jones, Helen

HAYMAN, IRVING R.—Paterson (in service)
Experiences with anesthesia in combat areas. War Med. 6: 353-356, Dec. '44

HOFFMAN, H. V.—see Johnson, J. F.

JOHNSON, J. F., and H. V. HOFFMAN — Trenton. Eastern Aircraft, Trenton Division, General Motors Corporation
Rôle of industrial medicine in the rehabilitation of veterans. J. A. M. A. 126: 1073-1077, Dec. 23, 1945

JONES, HELEN; GEOFFREY RAKE and DOROTHY HAMRE—New Brunswick (Squibb Institute for Medical Research)
Cultivation of leishmania in the yolk sac of the developing chick embryo. Am. J. Trop. Med. 24: 381-383, Nov. '44

KOOPERSTEIN, SAMUEL I.—Jersey City (in service), with H. E. Bass
Demonstration of hidden apical chest lesions. Bull. U. S. Army Med. Dept. 84: 102-103, Jan. '45

LEATHEM, JAMES H., Ph.D.—(Rutgers University) New Brunswick
Antihormone problem in clinical endocrine therapy. J. Clin. Endocrinol. 4: 500-504, Oct. '44

MORRIS, WATSON B.—Springfield
International College of Surgeons; report of Committee to Study Post War Planning. J. M. Soc. New Jersey 42: 26-27, Jan. '45

MORROW, JOSEPH H., Ridgewood—see Segard, Christian P.

POMERANZ, RALPH—Newark (in service)
Spontaneous cholecystoduodenal fistula in a patient with a primary lepatoma of the liver. Radiology 43: 583, Dec. '44

RAKE, GEOFFREY—see Jones, Helen

SEGARD, CHRISTIAN P.—Leonia, and JOSEPH R. MORROW—Ridgewood, et al.
Synopsis of some of the important tropical diseases. J. M. Soc. New Jersey 42: 22-25, Jan. '45

SHOPE, RICHARD E.—Princeton, Dept. of Animal and Plant Pathology of Rockefeller Institute of Medical Research
Old, immediate, and contemporary contributions to our knowledge of pandemic influenza. Medicine 23: 415-455, Dec. '44

SUTTON, JOSEPH G.—Cedar Grove
Psychiatry in the post war era. J. M. Soc. New Jersey 42: 18-21, Jan. '45

UDINSKY, H. J.—Passaic
Reduction in total skin flora by the daily use of a soap containing dihydroxy hexachloro diphenyl methane. J. M. Soc. New Jersey 42: 15-17, Jan. '45

USHER, GLENN S., and H. COWAN—Trenton
Venereal diseases among the migrant farm laborers of New Jersey. J. M. Soc. New Jersey 42: 11-14, Jan. '45

WAKSMAN, SELMAN A., and E. BUGIE—New Brunswick (New Jersey Agricultural Experimental Station)
Chaetomin, a new antibiotic substance produced by chaetomium cochliodes. I. Formation and properties. J. Bact. 48: 527-530, Nov. '44

WAKSMAN, SELMAN A.—see also Geiger, Walton B.

# STATE ACTIVITIES

## MEETING OF THE BOARD OF TRUSTEES

The Board of Trustees held a regular meeting at 2:00 p. m., Sunday, January 28, 1945, in the Executive Offices, Trenton. Those present were: Dr. Norton, Chairman, who presided; Drs. Londrigan, Costello, McBride, Alexander, North, Green, Stahl, Schaaf, Hornberger, Crowe and Scammell. Drs. Fithian, Hawkes, Lee and Young were excused. Also present upon invitation were Drs. Hollinshed, Scott, Mount and Barkhorn.

### APPROVAL OF MINUTES

The minutes of the regular meeting on October 8, 1944, were unanimously approved.

### REPORT OF THE PRESIDENT

*Osteopaths*

President Londrigan reported that the Officers had met to consider a policy to be adopted by this Society relative to osteopathic physicians. A communication addressed to the Secretary of the A. M. A. requesting a statement of the principles and policies of that body in reference to osteopathic physicians has been referred to the Judicial Council of the A. M. A. Recommendations as to this Society's policy will be made to the Board after receipt of advice from the A. M. A.

*Licensure of Medical Officers, Veterans of World War II*

An amendment to the Medical Practice Act to permit the licensure of medical officers, veterans of this war, who had been residents of New Jersey for five years, without examination, was read by President Londrigan. The amendment was prepared by a Newark lawyer who requested that this Society present the amendment to the legislature for enactment.

After consideration and discussion, it was the Board's action that the Society's position, adopted on October 8th, of disapproving the licensing of veterans without examination be reiterated.

The Board directed that in the reply to the request for the introduction of this amendment it be stated that it is the Board's feeling that all legislation of this type should be held in abeyance until after the war.

*1945 Annual Meeting*

As a result of the ban on conventions and gatherings of over fifty persons, the State Society has made application to Washington for permission to hold the 1945 Annual Meeting in Atlantic City. No reply has as yet been received. By unanimous action of the Board, the President and Chairman of the Board were delegated with power to act in accordance with the decision from Washington in the plans and arrangements for the 1945 meeting.

*Health and Accident Insurance*

The Committee on Medical Defense and Insurance has considered the application of the Commercial Casualty Insurance Company for approval of its non-cancellable health and accident policy to members of County Societies. A report on this policy will be made to the Board after further study.

*Death of Dr. Conaway*

Chairman Norton appointed the following committee to draw up suitable resolutions on the death of Dr. Walt P. Conaway, Past-President, to be forwarded to his sister. Committee, Dr. Andrew F. McBride, Dr. Harry R. North and Dr. Ralph K. Hollinshed.

*Physical Fitness Committee*

In accordance with the request of the Welfare Committee on October 1st, the following members were appointed by the President to the Joint Committee on Federal Physical Fitness Program: Drs. Timothy W. McParland, Vincent P. Butler, Daniel F. Remer, Byron G. Sherman, Timothy H. Spillane and Harrold A. Murray.

### BONUS TO EXECUTIVE SECRETARY, LEGISLATIVE COMMITTEE

By unanimous action of the Board, the Executive Secretary to the Legislative Committee was voted a bonus of $1,000 for the fiscal year 1944-45, in view of the excellent work being carried on by him and the Legislative Committee, especially in connection with the chiropractic hearings held in October and November, 1944.

### REPORT OF THE FINANCE AND BUDGET COMMITTEE

The Board approved the recommendation that the Executive and Editorial Staffs be given an honorarium of one week's salary for their coöperation and assistance in readying the new Home for occupancy.

The Board concurred in the recommendation that the Society assume two-thirds of the bill of the court reporter in taking the testimony at the four chiropractic hearings; the State Board of Medical Examiners to assume the other third; the amount to be charged to the Contingent Fund as a special bill for legislative matters.

### REPORTS OF SPECIAL COMMITTEES

*Audit Committee*

The report of the Chairman of the Audit Committee, Dr. McBride, that the committee approved the audit report as submitted by the auditors for the State Society, was received.

*Permanent Home Committee*

Upon the recommendation of the Permanent Home Committee, the following items of expense were approved:

a. Purchase of Home—$30,000.00.
b. Renovations, equipment and operating costs to January 28, 1945—$11,437.18.

The Board authorized the Permanent Home Committee to expend monies up to $15,000 for future renovations and equipment for the home.

At the request of the Committee, the following policy regarding the use of the Home was adopted: That it be the policy of The Medical Society of New Jersey to rent meeting rooms in the Home of the Society only to the allied professions for business and professional meetings and that no social or club room privileges be permitted; each application subject to the approval of the Permanent Home Committee. The Board of Trustees reserves the right to terminate any agreement at any time and to cancel scheduled meetings of outside groups when they conflict with meetings of The Medical Society of New Jersey.

The rental of the third floor apartment, garage spaces and garage apartment was left in the hands of the Permanent Home Committee with power to act.

By unanimous action, the Board authorized the Permanent Home Committee to proceed in any matters in connection with the Home which come up and must be disposed of between meetings of the Board.

*Inter-Professional Relationships*

Dr. Hollinshed, Chairman, reported that his Committee had met on November 19th and decided to call in the liaison physicians between the attending staffs and the boards of managers of hospitals. This meeting was held on January 7 and each one present had an opportunity to express his views on the matter of corporate practice of medicine. The next meeting is scheduled for February 25th with the hospital medical directors, from which group the committee will choose five to seven additional members to the committee. The enlarged committee will then meet with representatives from the boards of managers of the hospitals, after which it is hoped the committee will be in a position to formulate a policy for presentation to the Trustees.

*Interne Training Program*

Dr. Schlichter, Chairman, submitted the following report. There has been no formal meeting of the Committee since the 1944 Annual Meeting. Several New Jersey hospitals have made informal inquiries concerning such a program, or have requested copies of the 1944 report and suggested outline of a program. Two voluntary hospitals have submitted an outline of recently inaugurated training programs. The situation as a whole remains the same as at the time of our 1944 annual report. Hospitals with adequate clinical material and training programs, with an attending medical staff manifesting sufficient interest in these young men, have no difficulty in obtaining adequate interne staffs. Several such hospitals have an over-abundance of applications from Class A graduates.

P. & A. is purely an advisory and administrative agency, with no authority or compulsive power. The only source of pressure or compelling force in this matter must come through the State Board of Medical Examiners or the Council on Hospitals and Medical Education of the A. M. A.

Applications of hospitals to obtain approval for appointment of residents on the basis of not being able to obtain sufficient internes cannot be approved by P. & A. Residents cannot be appointed to replace inadequate interne personnel.

A more complete report will be submitted later.

*X-Raying in Industry*

Dr. Hornberger, Chairman, reported that his committee is still gathering data on the subject from industry, labor and the medical men connected with the tuberculosis and x-ray fields. The committee is endeavoring to get a composite picture from these groups and expects to have definite proposals to offer for endorsement at the next meeting of the Board.

REPORT OF THE WELFARE COMMITTEE

The actions of the Subcommittees, as adopted by the Welfare Committee on January 21, 1945, were concurred in by the Board: By unanimous action, previous disapproval of N. P. C. by the Board was rescinded, and the resolutions adopted with minor changes.

It was directed that the Society's action opposing the curtailment of essential foods and supplies for the well-being of children, be communicated to the Board of Health, the Governor, the Senate and the House of Assembly.

MEDICAL-SURGICAL PLAN

The Board referred the following recommendation to the Officers of the Society with power to act: That the matter of a proposed dinner meeting with representatives of industry and labor, at which would be explained the program of The Medical Society of New Jersey to improve medical care distribution, and the objectives of the Medical-Surgical Plan be sponsored by The Medical Society of New Jersey.

As further evidence that the money appropriated to the Medical-Surgical Plan was a donation and involved no liability of repayment, the following resolution was adopted: Be it Resolved, that the appropriation of $5,000 made to Medical-Surgical Plan of New Jersey, by action of the Board on March 22, 1942, involves no liability upon Medical-Surgical Plan for repayment of the whole or any part of this appropriation.

An Audit Report on the Medical-Surgical Plan was referred to the Audit Committee, Dr. McBride, Chairman.

ESSEX COLLEGE OF MEDICINE AND SURGERY

A communication from the Secretary of the Council on Medical Education and Hospitals of the A. M. A., in reply to the Board's letter stating the attitude of the Society toward the College, was read. Dr. Johnson, Secretary of the Council, stated in his letter that his feeling relative to the College was in accord with that of the Society.

Dr. Schaaf briefly outlined the activities to date of the State Board of Medical Examiners in connection with the college. The school opened on January 2, 1945, and the authorities have been warned that if they persist in operating the school, which has not been brought up to the Class A standard, their license would be revoked.

ASSOCIATED HOSPITAL SERVICE OF NEW YORK

At the request of the Associated Hospital Service of New York, the Board recommended Dr. Edward W. Sprague and Dr. Samuel Cosgrove as nominees qualified to serve as directors of that corporation.

ADVISORY COMMITTEE ON DISTRIBUTION OF HEAVY CREAM

At the request of the Office of Distribution, U. S. Department of Agriculture, for approval of a panel of Newark physicians who have indicated their willingness to serve as an advisory committee in connection with sale and distribution of heavy cream, particularly to pass on requests from physicians for the use of heavy cream in the diets of patients, the Board approved the set-up now working in Essex County, provided recommendations continue to come from the Essex County Medical Society or from any other County Society in the State for that respective county.

STATE BOARD OF MEDICAL EXAMINERS

The Secretary of the Board was instructed to write to the Governor withdrawing all names of physicians previously recommended as candidates for appointment to the State Board of Medical Examiners.

The following candidates for appointment were approved; preference in order listed:

Term of Dr. Elmer P. Weigel, term expiring March 9, 1945:

Dr. Elmer P. Weigel, Plainfield
Dr. James F. Norton, Jersey City
Dr. Joseph F. Londrigan, Hoboken

Term of Dr. John H. Rowland, term expiring April 11, 1945

Dr. John H. Rowland, New Brunswick
Dr. Vincent P. Butler, Jersey City
Dr. Berthold S. Pollak, Jersey City

The Secretary of the Board was instructed to submit the above recommendations to the Governor for consideration. Also to state in the communication that following the appointment of one of the candidates for each term the remaining two names are automatically withdrawn.

HOSPITAL SERVICE PLAN OF NEW JERSEY

At the request of the Hospital Service Plan of New Jersey for the nomination of a repre-

sentative from the Medical Society on the Board of the Hospital Plan, the Trustees unanimously nominated President Londrigan.

H. R. 1391

H. R. 1391, introduced by Congressman Miller, a physician, of Nebraska, which would create a Department of National Health, headed by a Secretary of National Health to be appointed by the President, was called to the attention of the Board by President Londrigan, who stated he would, in his acknowledgment to Congressman Miller, urge that the Secretary of National Health be a physician.

The meeting adjourned at 4:40 p. m.

ALDRICH C. CROWE, M.D., secretary.

## WELFARE MEETING

The second meeting of the Welfare Committee was held at the Executive Offices, Trenton, on Sunday, January 21, 1945. Chairman Hornberger and President Londrigan expressed their appreciation to those present for their attendance in view of the inclement weather and poor traveling conditions.

President Londrigan expressed his personal appreciation to the Executive and Editorial Staffs, the House Committee and the Board of Trustees for their diligent work and cooperation in securing and readying the Society's permanent home for occupancy.

More support of the Medical-Surgical Plan, which is our answer to severe legislation being introduced in the Legislature, was stressed by Dr. Londrigan.

LEGISLATION

*Chiropractics*

Chairman Sica reported on the legislative hearings re chiropractics. (See page 56, February *Journal.*)

*Reorganization of State Departments*

On January 10, 1945, a hearing was arranged and held before the Commission on State Administrative Reorganization at which representatives of the allied societies: dental, pharmaceutical, nursing, medical, veterinary medicine and optometry, were present. It quickly became apparent that there was substance to the report that the Commission intended recommending that the examining boards of the medical and allied professions, and perhaps some others, be placed in the Department of Health.

Representatives of the groups present expressed themselves: (1) that the various professional licensing boards could render a better quality of service by being continued as separate entities; (2) *opposed* to being placed in the State Department of Health. In voicing opposition to the latter, it was argued that (1) the training of those entering the various professions was basically an educational matter; (2) with the increasing federal appropriations as grants-in-aid to the various activities of the State Health Department and with the present threat of complete control of medicine by the federal government, these professions did not wish to be placed in the department of state government which would be in a position to exert pressure upon the health professions.

So far as this Commission is concerned, we must expect recommendations that will call for some type of consolidation. As an alternate proposal the idea of creating a separate *department* embracing the Boards of Examiners of Medicine, Dentistry, Pharmacy, Nursing, Veterinary Medicine, and Optometry was tentatively advanced. The thought of creating a Department of Professional Licensure was broached, to embrace not only the medical and allied boards, but others such as architecture, surveyors, and perhaps the Bar Examiners as well. Finally the idea of putting all professional licensing boards, as a separate division, in the Department of Education was discussed.

Further steps to be taken must await the recommendations of the Commission.

*Federal Legislation*

In Congress, the Wagner-Murray-Dingell bill has again made its appearance, having been presented in the House on January 3 by Representative Dingell (H. R. 395). The medical provisions of this bill are identical with the Wagner-Murray-Dingell bill of the last Congress.

Congressman Miller, Nebraska (a physician), has introduced a bill, the purpose of which is to act as an offset to the Dingell Bill.

H. R. 284, introduced by Representative Randolph, West Virginia, would provide health programs for government employees. When action was taken on a similar bill in the closing of the last Congress, Senator Downey, California, submitted an amendment which

would have permitted osteopaths to participate in the health programs.

H. R. 610, introduced by Representative Tolan, California, proposes to amend the U. S. Employee's Compensation Act to permit chiropractors to treat beneficiaries. This is the third year this proposal has been introduced.

*State Legislation*

In the State Legislature thus far, only two bills of medical interest have been introduced. These, with others, which will probably make their appearance within the next two or three weeks, will be referred to in Legislative Bulletin No. 2.

MEDICAL PRACTICE

Chairman Johnsen reported for his Committee.

*Resolution from New Jersey State Medical Association*

The communication and resolution from the New Jersey State Medical Association on the situation of the Negro doctor, referred to the Subcommittee for consideration by the Welfare Committee, was returned to the Welfare Committee with the recommendation that no action be taken at present, but that it be filed for future study and reference.

*Post-War Planning*

The Committee has not ceased working on the problem, but there are no specific steps to take at present.

*Revision of Workmen's Compensation Act*

At the meeting of the Committee from the Medical Society, Drs. Johnsen, Harryman and Quigley, with Judge Eastwood, Chairman of the State Commission of Post War Economic Welfare, in December, the following recommendations were presented for consideration:

A free choice of physician by the injured employee requires certain safeguards so that the employer (carrier) may be afforded an opportunity of determining the nature of the injury of the employee and the progress of restoration.

The State Medical Examiners should be full-time men, not engaged in private practice. A small group of the State Medical Examiners should be appointed to pass upon the amount of permanent disability in all compensation cases. This unquestionably would do away with the present unsound system of compromise on the amount of permanent disability on compensation cases.

In cases where it is felt by the employee or the employer (carrier) that proper treatment is not being carried out, a State Medical Examiner may order the removal of this case from the attending physician's care and place it in the hands of some properly authorized physician or institution for further treatment.

Some definite plan should be made to modernize the present system of occupational disease.

It is recommended that a committee consisting of appointees from the Department of Labor and from The Medical Society of New Jersey be established to pass upon questionable medical testimony which may have been given before a Commission, and to review this testimony and make proper recommendations.

An attempt should be made to have informal hearings truly informal. If possible they should be held in a room separate from the general court, where the referee, the plaintiff and a representative for the defendant can discuss the case in a friendly manner, rather than in the formal atmosphere of a court.

The provisions of the act requiring *all* employers to carry compensation should be strictly enforced.

It is also recommended that no award of permanent partial disability be given until the maximum degree of recovery has been reached.

Attention is also called to the report of Dr. Andrew F. McBride, former Commissioner of Labor, made in 1933, called the Report of Joint Commission, reference Chapter JR 16 PL 1913 and Chapter JR 5 PL 1934, on study of Workmen's Compensation Act and Practices, which contains many worthwhile suggestions.

In reply to the Committee inquiry as to whether there were any phases of the problem which touched on Medical Practice which the Commission was considering, Judge Eastwood replied that a proposal had been made to enact into law provisions whereby benefits could be paid to workers who were disabled by reason of illness. This fund would be derived from the Unemployment Fund of the Social Security Account.

*National Physicians' Committee*

The resolutions on the National Physicians' Committee (see page 55) were adopted.

*EMIC Program*

Since the meetings of the Medical Practice Committee are devoted mainly to reports of its advisory committees and there is insufficient time left to discuss special matter, the EMIC Program would be assigned to one of the advisory committees, so that the problems arising in the administration of the program could be given proper consideration.

Upon recommendation of the Medical Practice Committee, and in accordance with the interpretation of the resolutions passed at the

1944 Annual Meeting that the Society continue its support of the EMIC Program, the Welfare Committee adopted the definitions of major, intermediate, and minor surgery as working definitions pending modification or changes by the advisory committee to which the program is assigned.

The following amendments were also approved:

1. To permit the establishment of rates 50 per cent higher than the rates now in effect for specialists in obstetrics, pediatrics and other types of medical services.

2. For individually adjusted payment for care of sick infants and for nonobstetric intercurrent conditions in maternity patients.

Two amendments to provide a rate of payment on an annual basis for office medical care of sick infants, immunizations, general advice on care of the infant and complete health supervision, were disapproved.

*Veterans Administration Clinics*

From the report of Dr. Grier, Chairman of the Advisory Committee on the Distribution of Medical Care, it was learned that the Veterans Administration, at several points in New Jersey, is starting clinics where servicemen with non-service connected complaints and disabilities are treated. The physician's salary is $3800 per year with $100 a month deducted if he is fed by the Veterans Administration. Such clinics are allowable under the December 14, 1944, amendment to the G. I. Bill of Rights.

The Welfare Committee concurred in the recommendation of the Subcommittee that the Medical Society go on record as disapproving of the formation of clinics and of house visits for non-service connected disabilities of veterans, and that a protest be forwarded to the Veterans Bureau.

*Veterans Administration Fees*

A communication from the Chief Medical Officer, Veterans Administration, Lyons, to Dr. Ruoff, Chairman of the Advisory Committee on Contract Practice, relative to fees was submitted for publication in the *Journal*. (See page 55.)

*Physicians' Certificates of Absenteeism*

Dr. Carlisle called the attention of the Welfare Committee to absenteeism in industry and the misuse of the private physicians' certificate. He stated that his Committee on Industrial Health and Hygiene had received a number of requests to talk over some of the problems that have arisen from the misuse of the certificates. A number of certificates have been analyzed and studied and it would appear that there are about 10 per cent non-bona fide certificates. This effort is of great importance today and an appeal has been made to the private physicians to certify only those absentees they know specifically about or have treated during their entire illness.

*Industrial Medicine*

Dr. Carlisle also reported that his committee is working along with the Post-Graduate Committee on Education for the returning service physicians in industrial medicine. A number of industries have full-time or part-time medical men and are anxious to pay their way in these graduate courses. The medical profession should know these services are available, and it has been taken up with the American Association of Industrial Physicians who have the program outlined.

PUBLIC HEALTH

In the absence of the Chairman, Dr. Dilger, the report was presented by Dr. Murray.

*Child Health*

The Welfare Committee concurred in the recommendation that the Society go on record as being opposed to the curtailment of essential foods and supplies for the well being of children.

*Cancer*

The following recommendations were approved by the Welfare Committee:

1. That an up-to-date list of Tumor Clinics in the state, together with the names of the directors, be placed on file in the State Medical Society Executive Offices in Trenton. Also a copy of the rules and regulations governing these clinics.

2. That the Association of Tumor Clinics be the guiding force in the development of the cancer control work in the State of New Jersey.

3. That the State Executive Committee of the Women's Field Army include in its membership the entire personnel of the Cancer Committee of the Medical Society.

4. That the preventive control of cancer be a part of the established cancer clinics throughout the State.

5. That the key man in any successful cancer control program be the family physician. The Committee feels that any program of cancer control that does not properly incorporate the activities of the family physician is bound to fail.

*Enrichment of White Bread*

Upon recommendation of the Subcommittee the Welfare Committee concurred in the action that the Medical Society go on record as favoring legislation making it mandatory for all white bread sold in New Jersey to be enriched in accordance with the standards for enriched bread adopted by the Federal Food and Drug Administration.

*Venereal Disease*

The Venereal Disease Control Committee is instituting an educational program for physicians through the Bureau of V. D. Control. The Committee also hopes to institute legislation to aid in the control of venereal disease among migrant workers.

*Tuberculosis*

Conferences are being held to consider the problem of recalcitrant tuberculosis patients. There is a law by which recalcitrant tuberculosis patients who endanger the health of the public and their families may be committed to a county tuberculosis hospital by court order. However, there is no way to keep the patient in the hospital if he does not wish to stay. It is hoped that real progress will be made toward the solution of this problem as a result of the conferences.

The meeting adjourned at 3:30 p. m.

EDITH L. MADDEN,
Acting Executive Officer.

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## VETERANS ADMINISTRATION FEES

The following communication received by the Chairman of the Advisory Committee on Contract Practice is published for the information of the members:

January 19, 1945

Dr. Andrew C. Ruoff
2414 New York Avenue
Union City, N. J.

Dear Dr. Ruoff:

In reply to your letter concerning the fees of the Veterans Administration for fee basis physicians, the maximum fee allowed in our schedule of fees is $2.00 for office calls and $3.00 for home calls and these are now in effect. The night visit (emergency) maximum is $5.00 and $5.00 for physical examination and report. We are now allowing $4.50 for night emergencies and physical examination. Effective Feb. 1, 1945, this fee will be increased to $5.00 for each.

Very truly yours,

L. V. LOPEZ, Lt. Col., M.C.,
Chief Medical Officer,
Veterans Administration,
Lyons, New Jersey.

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## NATIONAL PHYSICIANS' COMMITTEE

The following resolutions, recommended by the Subcommittee on Medical Practice and approved by the Welfare Committee on January 21, 1945, were endorsed by the Board of Trustees on January 28, 1945.

*Whereas,* The physicians of the United States through the American Medical Association have by their efforts over a period of one hundred years developed American Medicine to the point of a general recognition of its worldwide leadership, and

*Whereas,* These same physicians have and are giving the best medical care in the world to our armed forces of the United States, and

*Whereas,* The American Public has been and is subjected to a vast educational propaganda, some of which tends to discredit the American doctor and to destroy con-

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fidence in the effectiveness of American medicine;

*Therefore, Be It Resolved,* That The Medical Society of New Jersey register its approval of the activities of the National Physicians' Committee for the Extension of Medical Service, commend the Board of Trustees and management of that institution for the efforts they have made to enlighten the general public in connection with the methods of American Medicine, progress of achievements, and in pointing out that the public has a vital interest in the final result; and

*Be It Further Resolved,* That The Medical Society of New Jersey encourage this effort and similar efforts with identical purposes.

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## CHIROPRACTIC HEARINGS

There were four joint hearings held by the committees of the Senate and the Assembly, which were appointed to make a study of the licensing and regulating of chiropractic in this state, and to make such recommendations as they deem necessary. At the first hearing the chiropractors held forth, and their speakers took up considerable time with discussion of constitutional privileges and the Bill of Rights. Quite some time was devoted to an attack upon our "limited license" act, under which chiropractors have been licensed since 1921, and which became inoperative July 31st of last year. Charges were made and reiterated, but never substantiated, that the Board of Medical Examiners had been arbitrary and unfair in the matter of licensing chiropractors and in accrediting their schools.

At the second hearing our Society held forth, and started off by having the President give a brief historical sketch of the Society. Other speakers, including Dr. Alexander, Dr. McBride and Dr. Liva, took up from the time that the licensing of those who practice the healing arts was taken over by the State in 1894 to the passage of the chiropractic act of 1920, which set up a separate board of chiropractic examiners, and which was repealed one year later and supplanted by the "limited license" act, and finally to the act of 1939 which made it necessary for all practitioners, regardless of their label, to meet equivalent educational requirements in all respects. Dr. Liva's testimony convincingly controverted charges of arbitrariness and unfairness on the part of the Board of Medical Examiners in dealing with chiropractors. As one of our speakers we had the Dean of Jefferson Medical School, Dr. William H. Perkins, who outlined what constituted an acceptable medical school. He did this very well and made a good impression. Our position in opposing a separate board of chiropractic examiners, with lower educational requirements, was supported by representatives of the New Jersey State Dental Society, the New Jersey Pharmaceutical Association, the New Jersey State Nurses' Association, the New Jersey Osteopathic Society and the New Jersey Chiropodists' Society. Before the hearing closed some catalogues of a few of the chiropractic schools were discussed and such points as the National Chiropractic College in Chicago conferring the degree of doctor of chiropractic "cum laude" were brought out.

The third and fourth hearings were largely taken up by the chiropractors in rebuttal. We took about an hour and a quarter to wind up the proceedings, and discussed at greater length the "courses" given in the chiropractic schools and their "faculties", etc.

At the third hearing, in response to a question from one of the members of the Assembly Committee, Dr. Nugent, Educational Director of the National Chiropractic Association, disclosed that their Association now recognizes four schools as approved, namely: the National College of Chiropractic, Chicago; the Western States College, Portland, Oregon; the Lincoln Chiropractic College, Indianapolis, and the Institute of the Science and Art of Chiropractic, New York City.

During the two weeks' interval between the third and fourth hearings the following was ascertained with respect to the Institute of the Science and Art of Chiropractic, located in New York City: This school apparently is an amalgamation of three chiropractic schools, the New York School of Chiropractic, the Eastern Chiropractic Institute and the Standard Institute of Chiropractic. The Eastern Chiropractic Institute operated in New Jersey under the title of the Eastern Chiropractic College until about 1924 when it migrated to New York City and located at 55 W. 42nd Street, which apparently was the location of the other two schools. While the Eastern College was operating in New Jersey it got into difficulties with the Attorney General's office for conferring degrees without approval of the State

Board of Education. The president of this school, Craig Kightlinger, 47 Parkview Drive, Millburn, New Jersey, ran into this trouble in New York City, where he and the dean, Julius Jacobs, were convicted of violation of section 66 of the education law (conferring degrees) December 28, 1934. On September 22, 1930, Kightlinger was convicted of the unlawful practice of medicine in New York County. One of the leading lights in the new "institute", Thor C. Peterson, who resides at 852 Valley Road, Upper Montclair, New Jersey, and who was closely identified with the New York School of Chiropractic, was convicted on a charge of having conferred the degree of chiropractic in contravention of section 66 of the state education law.

A letter from New York State Education Department advises that neither the Institute of the Science and Art of Chiropractic nor any other chiropractic school is registered with the Education Department and consequently is operating without authority of law.

The information as to the Institute of the Science and Art of Chiropractic given above, and more, was presented at the fourth hearing as testimony and is included in the transcript of the proceedings.

What sort of reports these two committees will make, of course, we do not know. Their composition was such that we could not exactly expect an unbiased opinion. The Chairman of the Assembly Committee, Miss Doremus, was the introducer of a bill at the last session of the Legislature to set up a separate board of chiropractic examiners, and the Chairman of the Senate Committee, Senator Stangler, likewise was the introducer of a bill to effect this purpose, and has introduced several other bills of this character in the past ten years. However, we are hopeful that we shall not come out too badly. In any event we may expect the introduction of chiropractic bills at the 1945 session of the Legislature.

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## STATE BOARD OF MEDICAL EXAMINERS

E. S. HALLINGER, M.D., Secretary

Following is a report of the activities of the Board in enforcing the Medical Practice Act:

April 8, 1944, Naomi May Tompkins of Dover, a nurse, paid a penalty for practicing medicine without a license. Mrs. Tompkins gave colonic irrigations, short wave treatments and medicine.

April 26, 1944, the license to practice medicine and surgery of Morton Reese, M.D., of Mount Clemens, Michigan, was revoked by the Board for conviction of a violation of the Harrison Narcotic Act.

May 4, 1944, Morton Holzman, D.S.C., of Camden, paid a penalty for continuing to practice chiropody after having failed to obtain an annual certificate of registration.

May 4, 1944, James Roy McKay of Merchantville, a physio-therapist, paid a penalty for practicing medicine without a license. This was the second case against him.

May 18, 1944, Lillian Prien of Hackensack, a masseuse, was tried before Judge Randall of the First Judicial District Court of the County of Bergen and found guilty of practicing medicine without a license. She massaged, gave electric treatments, strapped feet, applied arch supports and ordered various remedies.

May 31, 1944, Felicia Kornreich of Paterson was committed to jail for thirty days. Mrs. Kornreich was convicted April 22, 1943, on a charge of practicing medicine without a license and failed to pay the penalty. She operates a health food store, calls herself a nutritionist and prescribes various foods and medicines. This was the third case against her.

June 7, 1944, Aeneas C. Macdonald of Atlantic City was tried in the Atlantic City District Court on a charge of practicing medicine without a license and decision reserved. On June 27, 1944, a judgment of no cause for action was entered. Macdonald demonstrated and dispensed the "Selrodo" machine for the treatment of various respiratory ailments, gave vitamins, herbs, sulfa tablets and ordered Lugol's solution, occy-crystine and other drugs.

June 8, 1944, Constantine Pankevich, Sr., of Cranbury, a registered pharmacist, paid a penalty for practicing medicine without a license.

June 8, 1944, Florence B. Haines of Ocean City paid a penalty for practicing medicine without a license. She gave manipulative treatment and medicine. This was the third case against Mrs. Haines, whose husband and son are both licensed physicians.

June 8, 1944, Harry Garber of Grantwood, an unlicensed chiropractor, paid a penalty for prac-

ticing medicine without a license. Garber gave adjustments and short wave treatments.

June 14, 1944, the license to practice medicine and surgery of Francis Aloysius Mulholland, M.D., was revoked by the Board on a charge of conviction of the crime of criminal abortion.

June 22, 1944, Earl E. Kailey of Trenton, an unlicensed chiropractor, paid a penalty for practicing medicine without a license. This was a third case against him.

June 22, 1944, Herman H. Farber of Union City, an unlicensed chiropractor, paid a penalty for practicing medicine without a license. This is the fourth time he has paid a penalty.

June 22, 1944, Waymon V. Bell of Paterson, an unlicensed physician, paid a penalty for practicing medicine without a license. He examined with a stethoscope, took blood pressure, wrote prescriptions, gave medicine and hypodermic injections.

July 6, 1944, William Steepy of Passaic, clerk in a drug store, paid a penalty for practicing medicine without a license.

July 18, 1944, Jose Fernandez Quirago of Newark was tried before Judge MacMahon of the First District Court of Newark and found guilty of practicing medicine without a license. Quirago claimed to have graduated from a medical school in Spain.

August 10, 1944, the Supreme Court rendered a decision in favor of the Board in the case against George H. Coleman of Kearny, an unlicensed chiropractor who was found guilty of practicing medicine without a license on June 22, 1943, in the First District Court of Jersey City. The Board sued for a second offense penalty but the Court imposed a penalty for a first offense, therefore, the Board appealed to the Supreme Court.

September 14, 1944, decision in the case of Minnie Black, a licensd chiropractor of East Orange, who was found guilty of practicing medicine without a license by Judge MacMahon of the First District Court of Newark on November 6, 1940, and subsequently appealed to the Supreme Court and Court of Errors and Appeals, was affirmed by the latter Court. She exceeded her chiropractic license by practicing iridology and prescribing medicine.

November 6, 1944, Adeline D. Risatti of New Brunswick, an unlicensed chiropractor, paid a penalty for practicing medicine without a license. This was the second case against her.

November 6, 1944, Michael Nogradi of New Brunswick, an unlicensed chiropractor, paid a penalty for practicing medicine without a license. This was the third case against him.

December 7, 1944, Frank Shamy of New Brunswick, a masseur, paid a penalty for practicing medicine without a license. He gave massage and diathermy treatments.

December 7, 1944, William S. McElmoyle of Gloucester, a naturopath, paid a penalty for practicing medicine without a license. He gave manipulative treatment and electric treatment.

December 7, 1944, Joseph M. Grossman of Perth Amboy, an unlicensed chiropractor, paid a penalty for practicing medicine without a license. This was the second case against him.

December 7, 1944, William D. Taylor of East Orange, an unlicensed chiropractor, paid a penalty for practicing medicine without a license. This was the second case against Taylor, who gave manipulative and electric treatments and diets.

January 10, 1944, petition for reinstatement of the license to practice medicine and surgery of George Lemke, M.D., of Saint Paul, Minnesota, was denied by the Board.

July 7, 1943, Michael Feinstein of Camden, a registered pharmacist, pleaded guilty to a charge of practicing medicine without a license in the Camden District Court.

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## OBITUARIES

### DR. ANNA L. ALLABEN

Dr. Anna L. Allaben, Morristown's first woman physician and for many years president of the Morristown Board of Health, died of a heart ailment on January 2, 1945. She had been a practicing physician for the past fifty years.

Dr. Allaben was born in Oxford, N. Y., on September 22, 1858. She was graduated from the Woman's Homeopathic College and Hospital of New York in 1894, and following her graduation she was associated with Dr. William Helmuth in New York City.

Dr. Allaben came to Morristown to practice in 1895. She was on the staff of All Souls Hospital, and for many years was school physician for the Morristown school system.

Dr. Allaben was a member of the New Jersey Homeopathic Society, and until 1942 a member of the Morris County Medical Society.

### DR. J. HENRY CLARK

Dr. J. Henry Clark, who served 34 years as Newark police surgeon, died on January 1, 1945, at his home in Montclair, after a long illness. He had lived there since his retirement from active practice in Newark 12 years ago.

Dr. Clark was born in Newark on August 8, 1855, and received his early education at home, in Montclair High School and Williston Seminary in East Hampton, Mass., before entering Williams College, from which he was graduated in 1876. He was graduated from the College of Physicians and Surgeons in New York in 1881 and began to practice medicine in Newark the following year.

In 1883 Dr. Clark was appointed eye and ear surgeon at St. Michael's Hospital, a post which he held until 1915, when he was given the title of surgeon emeritus. He also served eight years as surgeon at St. Barnabas Hospital.

He was a member of the Sons of the American Revolution, the Essex County Medical Society, The Medical Society of New Jersey, the American Medical Association and the William Pierson Medical Library Association.

## DR. RICHARD COE

Dr. Richard Coe, formerly of Newark, died at his home in West End on January 1, 1945.

Dr. Coe was born in Hanover, Germany, on April 20, 1874. He was graduated from the Royal Gymnasium in his native land and after working as a druggist in Germany several years, came to New Jersey.

He received his medical degree from the University of Vermont in 1900, and began practicing in New Jersey, specializing in major surgery and diseases of the stomach. He took post-graduate courses with the Mayo Brothers in Rochester, Minn., and also studied at the Post Graduate Medical School, New York, and at Polyclinic Hospital and Medical School, New York. He also took courses at the Universities of Berlin, Vienna, London and Paris.

Having finished his post-graduate work, Dr. Coe returned to Newark and was made consulting proctologist at the Essex County Hospital at Overbrook. He was also attached in the same capacity at the Cornell Medical School for some time.

In 1899 Dr. Coe was made a Department of Health physician in Newark and was appointed chief of the clinic for children.

Dr. Coe was a member of the Essex County Medical Society, the Academy of Medicine of Northern New Jersey, The Medical Society of New Jersey, the American Medical Association and the New Jersey Pharmaceutical Association.

## DR. J. HOWARD COOPER

Dr. J. Howard Cooper, one of the last of the old school country doctors in Somerset County, died unexpectedly of a heart attack on December 31, 1944.

Born in 1867, Dr. Cooper was graduated from the Medical School of the University of Pennsylvania in 1891. He started to practice medicine in Middlebush and later moved to East Millstone.

When the Somerset County Medical Society observed its 125th anniversary in 1941, Dr. Cooper, President of the Society at the time, was one of three physicians honored for their membership of 50 years or more. He served the society in several other capacities and was prominent in its activities up to the time of his death.

Dr. Cooper was a member of the courtesy staff of Somerset Hospital, and for years he held the office of inspector of health and physician for Franklin Township.

Dr. Cooper was a member of the Somerset County Medical Society, The Medical Society of New Jersey and the American Medical Association.

## DR. LOUIS W. DODSON

Dr. Louis W. Dodson of Jersey City died on January 8, 1945, following an illness of several months.

Dr. Dodson was born in Jersey City on August 7, 1870. He attended New York University Pre-Medical School and was graduated from Bellevue School of Medicine in 1891. After graduation he was affiliated with the staff of the Binghamton State Hospital, but disliking institutional work he moved to Jersey City in 1902 and started private practice.

Dr. Dodson was chief medical examiner of the Prudential Insurance Company, medical director of the Expressmen's Mutual Life Insurance Company and county physician to the State Athletic Commission.

Dr. Dodson was a Past-President of the Hudson County Medical Society, and a member of The Medical Society of New Jersey and the American Medical Association. He was one of the charter members of the Physicians and Surgeons Club.

## DR. M. JAMES FINE

Dr. M. James Fine, tuberculosis specialist and director of the Newark Health Department Tuberculosis Bureau more than 25 years, died on December 17, 1944, after he suffered a heart attack. He was 60.

In addition to his Newark duties, Dr. Fine was Tuberculosis Consultant to the State Health Department. He was the first physician in the country to establish an outpatient pneumothorax clinic, having inaugurated such a clinic in Newark in 1920, and he was one of the first advocates of lung collapse as a treatment of early tubercular conditions.

Dr. Fine recently was commissioned a major in the Army Medical Corps Reserve, on inactive status. He was a lieutenant in the Medical Corps in World War I.

Dr. Fine received his medical degree in 1910 from the University of Maryland. He was named a clinic physician of the Newark Health Department in 1913, and was appointed consulting physician of the Tuberculosis Division of the State Health Department in 1926. Dr. Fine served in many capacities as a tuberculosis specialist during his career. He was chief of tuberculosis service at City Hospital, tuberculosis consultant for Newark Beth Israel Hospital, medical consultant to the rehabilitation clinics of the State Department of Labor, physician to the Essex County Juvenile Court, examining physician to the National Tuberculosis Hospital at Denver, consulting and examining physician to the Deborah Tuberculosis Hospital at Browns Mills and chairman of the medical and pediatrics section of the Academy of Medicine of Northern New Jersey for one year.

In March, 1942, Dr. Fine was appointed a member of the consulting staff of Essex Mountain Sanatorium in Verona, where he was named director of internal medicine.

Dr. Fine was a member of the Essex County Medical Society, The Medical Society of New Jersey, the American Medical Association and an executive member of the New Jersey Sanitary Association.

### DR. FRANK G. HEINIG

Dr. Frank G. Heinig, former resident of Boonton, died on December 31, 1944, at Batavia, New York.

Dr. Heinig was born in 1897 and was graduated from New York University College of Medicine in 1925.

Dr. Heinig practiced medicine in Boonton for many years, moving to Batavia about four years ago. He is a veteran of World War I and a member of the Boonton Post of the American Legion.

### DR. EUGENE J. LUIPPOLD

Dr. Eugene J. Luippold, who had practiced medicine in Weehawken for 37 years, died at his home on December 16, 1944. Death was due to complications which followed an operation performed on November 1, 1944.

Dr. Luippold was born in Brooklyn in 1886. He was graduated from the Baltimore Medical College in 1907. He later interned at Maryland General Hospital.

Dr. Luippold was a past president of the Union City Rotary Club. He was a member of the Hudson County Medical Society, The Medical Society of New Jersey and the American Medical Association. He was a Fellow of the American College of Physicians and the New York Academy of Medicine.

### DR. HERBERT E. McLEAN

Dr. Herbert E. McLean of Jersey City died shortly after he had been stricken with a heart attack on January 9, 1945.

Dr. McLean was born in Jersey City on April 12, 1897. He received his medical degree at the University of Maryland in 1923, and served his internship at Kinard Hospital for Crippled Children, Baltimore, and at Christ Hospital, Jersey City. He was attending physician in orthopedics at Christ Hospital and was also on the staff of Post Graduate Hospital in New York.

Dr. McLean was a member of the Hudson County Medical Society, The Medical Society of New Jersey, the American Medical Association and the Eastern Society of Anesthetists.

### DR. ADRIAN X. URBANSKI

Dr. Adrian X. Urbanski of Perth Amboy died on November 9, 1944, at the Columbia Presbyterian Medical Center, New York City, after a prolonged illness.

Dr. Urbanski was born in Perth Amboy in 1898. After pre-medical courses at Rutgers University he was graduated from the Medical College of Virginia in 1924.

Dr. Urbanski served as city physician from 1926 to 1936. He was attending surgeon at the Perth Amboy Hospital. He was a member of the Middlesex County Medical Society, The Medical Society of New Jersey and the American Medical Association.

Dr. Urbanski is survived by his mother, Mrs. Agnes Urbanski, and a brother, Dr. Matthew F. Urbanski of Perth Amboy.

### DR. A. WARD VAN RIPER

Dr. A. Ward Van Riper, president of the medical staff of Passaic General Hospital and dean of that city's physicians, died on December 22, 1944.

Dr. Van Riper was born in 1870, son of Dr. Cornelius Van Riper, also a well-known physician and first president of the medical staff of the General Hospital in Passaic. Dr. Van Riper studied at New York University and the College of Physicians and Surgeons in New York, specializing in children's diseases. He received his medical degree in 1895.

Dr. Van Riper was an honorary member of the Passaic County Medical Society, a member of The Medical Society of New Jersey and the American Medical Association.

### DR. HAMILTON VREELAND

Dr. Hamilton Vreeland of Ridgewod died on January 12, 1945, in his eighty-sixth year.

Dr. Vreeland was born in Jersey City on March 23, 1859. He attended Hasbrouck Institute and after taking a course in veterinary surgery, studied for his medical degree at New York University. He was graduated with high honors in 1885.

Dr. Vreeland practiced medicine in Jersey City for 40 years before moving to Ridgewood 18 years ago. His hobby was camping and game hunting.

Dr. Vreeland was a member of the Sons of the American Revolution, and an honorary member of the Hudson County Medical Society.

### DR. WILLIAM L. WILLIAMSON

Dr. William L. Williamson, former school trustee, former chief medical examiner of the Bayonne Board of Education and chief physician at the Hudson County Contagious Disease Hospital, died suddenly on December 29, 1944.

Born in Muncy, Pa., in 1876, and receiving his early education there and at Lafayette College, Dr. Williamson did not establish himself in Bayonne until 1918, but in the years that followed he became one of the city's leading practitioners and outstanding civic worker.

Following his graduation from Lafayette College, Dr. Williamson attended the New York Homeopathic Institute of Flower Hospital and following his graduation in 1916, was associated in the practice of medicine with Dr. Joseph Nevin in Jersey City.

He was a member of the medical staff of the Bayonne Hospital and was director of pediatrics. He was a past president of the Bayonne and Hudson County Medical Societies, former vice-president of the Hudson County Mosquito Commission, and a member of The Medical Society of New Jersey and the American Medical Association.

# COUNTY SOCIETY REPORTS

## ATLANTIC COUNTY

Walter B. Stewart, M.D., Reporter

The regular meeting of the *Atlantic County Medical Society* was held in the Hotel Chelsea, Atlantic City, on December 8, 1944, at 9 p.m. The President, DR. CHARLES HYMAN, presided. The speaker of the evening was DR. JOHN B. MONTGOMERY, Clinical Professor of Gynecology at Jefferson Medical College, who took as his subject "The Diagnosis and Treatment of Functional Menstrual Disorders".

Dr. Montgomery introduced the discussions with a descriptive analysis of the physiology of menstruation, since menstrual disorders deal with abnormal or disturbed physiology. Many of the symptoms have no organic basis. The causes of dysmenorrhea and amenorrhea may be classified as: (1) general debilitating conditions; (2) previous infections; (3) a functional group of uncertain etiology, but probably involving a failure of the endocrine glands to function, such as the anterior pituitary, or a failure of the receptor tissue to respond; and (4) nervous and emotional. An example of this last group is the onset of dysmenorrhea in a girl following a violent quarrel with her mother.

Functional uterine bleeding may occur at any age, but especially at the menopause or in adolescence. In addition to the above causes, blood dyscrasias may be a factor and must always be considered. Bleeding may be associated with failure of ovulation or with a cystic ovary. Examination of the urine may show an increase of estrogen content. The uterus is normal in size, but the endometrium is usually hypertrophied. No one knows what instigates the bleeding mechanism. Since there is some definite relationship with the thyroid gland, it is usually best to give thyroid in treatment, even though the metabolism is normal. Complete blood studies are essential. Diagnostic curettage and examination under anesthesia must be done. Hormone assays, though not too valuable, can be done when possible.

In all abnormal bleeding after the age of 40, one must first rule out cancer, then try to stop the bleeding with radium or x-ray.

Many girls at puberty, or even in maturity, do not need treatment other than by assurative or palliative methods. Bleeding is usually controlled by rest in bed, ergot, sedatives and vitamin K, or when severe, by transfusion and plasma. Bleeding is a symptom which can be helped by improving the general health and controlling the emotions. When the bleeding is severe, therapeutic curettage is advisable; in some cases it must be repeated several times.

Among the hormones, therapy with thyroid is the best. Chorionic gonadotropin should be used with great caution. Estrogens are of no value. Progesterone is logical and may be used with caution for a short time in dosage of 60 to 100 mgms. for six or seven days. Testosterone is worth trying and may give good results, with dosage of 200 to 500 mgms. during one cycle. Radiation in the young has not been used in the past ten years. Hysterectomy has a limited place in treatment.

Amenorrhea has much the same physiological background as do the bleeding cases, and involves mostly a failure of the ovarian hormone. In general, the same line of treatment is used as for the bleeders. Thyroid improves the condition. Emotional control is often necessary. Curettage will frequently initiate bleeding. Examination of vaginal smears is helpful. Estrogens are useful as replacement hormones. Progesterone is the best form, and the least harmful. In general, the best line of attack in these cases is elimination of organic disease, use of general measures, reassurance of patient, and rational hormone therapy.

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## BERGEN COUNTY

H. E. Reinhold, M.D., Reporter

The regular meeting of the *Bergen County Medical Society* was held at Hackensack Hospital on the evening of December 12, 1944, and was called to order by the President, DR. WILLIAM K. HARRYMAN, at 9:20 p.m.

The President spoke of the financial problem facing the Society and discussed our annual deficit, which last year amounted to $400.00. He proposed that a solution to this pressing problem might be an increase in the annual dues, either in the form of an assessment or an outright increase in the annual rate of dues.

Dr. Littwin suggested that the Treasurer should show on the annual statements presented to the members what portion of the annual dues goes to the State Society and what is retained by the County Society.

DR. C. W. HARREYS of Ridgewood was elected to Courtesy Membership and DR. S. K. FOOTE of Wyckoff and DR. C. B. KELLEY of Tenafly were elected to Regular Membership.

NORMAN M. SCOTT, M.D., Medical Director of the Medical-Surgical Plan of New Jersey, spoke on "Medical Care Distribution Problem".

The speaker stressed the fact that a change in the distribution of medical care for catastrophic illnesses is demanded by people in all walks of life and is no longer a proposition demanded by starry-eyed idealists.

He briefly sketched legislation in force which provides medical care such as the G.I. Bill of Rights, the Rehabilitation Program, etc.

Although the present Wagner bill is a dead issue, new legislation might be expected in Washington when the new Congress convenes.

The speaker reiterated that the care of the medical indigent and indigent person is the obligation of the community. To answer the problem in New Jersey, the Medical-Surgical Plan was evolved by the State Society and insures the cost of surgical and medical care in the hospital for employed persons and their families who have an income of $2,000.00 per year, plus $500.00 for the first de-

pendent and $250.00 each subsequent dependent up to $3,000.00.

It was pointed out that the Plan's income per month per person is 67 cents and that the claim cost as of May 31st, 1944, was 57.4 per cent of the earned income. The operating cost during the first six months of operation was 51.2 per cent of the earned income and for July, 1944, it was 17.7 per cent of the earned income.

Dr. Scott made a plea for continued coöperation by the medical profession so that a fair trial of the Plan could assure successful solution of the problem then Government control might be found unnecessary.

## BURLINGTON COUNTY

T. B. Dickson, M.D., Reporter

The regular meeting of the *Burlington County Medical Society* was held on December 14, 1944, at the Riverton Country Club.

The guest speaker was LT. JOHN CLEMENT of Beverly. He related many of his experiences. Lt. Clement was assigned to a beach battalion and was on shore a short time after the first soldiers landed in an amphibious assault. He stated that the most important thing in attending to a wounded soldier was the treatment of shock. He did not close any wounds but tried to prevent infection and gas gangrene, and also stopped hemorrhage. Lt. Clement is now located at Princeton.

Lt. Clement was stationed for some time in North Africa, where he saw CAPT. DEAN LEFAVOR. Capt. LeFavor has charge of the medical wards of a Station Hospital. In addition to his medical duties, Capt. LeFavor has organized a six-piece orchestra, which, according to Lt. Clement, is excellent. Capt. LeFavor's parting words to Lt. Clement were: "Tell those quacks in Burlington County 'Hello!'"

MAJOR LOUIS VITERI of Mt. Holly was also present at this meeting. He made a short speech, telling some of his experiences in the hospital in England where he is stationed. Major Viteri was in this country on a short furlough and has returned to England.

The Nominating Committee selected Dr. Parry Scott as Nominating Delegate.

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The January meeting of the Society was held on January 11, 1945, at the Burlington County Hospital.

DR. C. ALEXANDER HATFIELD of Philadelphia spoke on "Perivascular Diseases". Dr. Hatfield described in detail the treatment of varicose veins, hemorrhoids and associated lesions. A question and answer period followed.

## CAMDEN COUNTY

Joseph C. Lovett, M.D., Reporter

The *Camden County Medical Society* held its monthly meeting January 2, 1945, at the Camden City Dispensary with DR. HENRY B. DECKER presiding. Thirty-one members were present.

The guest of the evening was DR. JOSEPH F. LONDRIGAN, President of The Medical Society of New Jersey. Dr. Londrigan spoke on the Murray-Wagner-Dingell bill.

Dr. Decker is studying a plan so the general practitioner may have opportunity for post-graduate work.

DR. J. LYNN MAHAFFEY spoke on the State Health Program. He said the program was continually being expanded.

The other guest present was MAJOR ALBERT SHAFER, who has just returned from the war area.

This being "Case Report" night, four papers were presented by members of the Society.

The first was "A Case of Malignant Change Occurring in Extensive Burns" by DR. FREDERICK ZIEGLER. This was of a man, age 46, who had an extensive burn of the left chest at the age of six years with marked scarring. Two years ago, he first noticed an ulcer at the lower part of scar tissue. The ulcer spread so that it was a mass of granulation type of tissue the size of a grape fruit when first seen by Dr. Ziegler. The patient was presented. There was a large tumor situated at the lower margin of the ribs. The rest of the chest showed scar tissue with islands of healthy skin grafts.

Dr. Reed spoke of the difficulty in making a diagnosis from the biopsy specimen. It resembled a sarcoma. Further study proved it to be an atypical carcinoma.

Dr. Jack, in discussing the paper, stressed the danger of metastasis in the pleura, also the importance of histological diagnosis. X-ray will not destroy a fungating lesion. The patient should have x-ray, then surgery followed by x-ray treatments. He did not feel as though this man's life could be saved.

Dr. Pratt stated the earlier these cases are treated the more hope there is of recovery.

Dr. Decker said a gumma should be ruled out before calling this a malignancy. He had seen some similar to this that proved to be gummas. He did not think there was an unfavorable prognosis here as it had lasted two years.

The second was "A Case of Violent Injury to the Abdomen" reported by DR. H. WESLEY JACK. The man received a violent injury to his abdomen when he was pinned between a steel box and a crane. He entered the West Jersey Homeopathic Hospital in marked shock. Operation revealed that neither the spleen nor the liver was ruptured. The duodenum was completely stripped of membrane. The jejunum was torn completely across in three places. The ascending colon was stripped of membrane and the abdomen was full of blood. The peritoneum was attached over the denuded areas. Areas of the jejunum were resected and an anastomosis done. He was given large transfusions of whole blood, also plasma and glucose. A colostomy was done. The patient had a stormy convalescence. The patient was discharged in good condition and was presented at the meeting.

Dr. Gamon in discussing the paper said it brings out the point of what massive blood transfusion

will do. It keeps the patient from going into shock. Such transfusions are being used in this war.

Dr. Jack stated he used sulfanilamide crystals in the abdomen in severe cases.

The third report was "A Case of Tularemia" reported by DR. WILLIAM J. SNAPE. This case presented two outstanding features. First, the confusing presence of pneumonia, and second, the patient was not extremely ill. He showed symptoms of viral pneumonia involving the left lung. He became worse on sulfonamide treatment. Then, there was noticed a small ulcer with a small amount of pus. The ulcer healed in ten days, and there was general improvement. The fixation test was positive for tularemia. The illness was followed by persistent fatigue and loss of weight. The patient regained his weight in six months' time.

There are pneumonic changes in tularemia and tularemia can also occur without any skin lesion.

Dr. Summerill in discussing the paper said he had a case several years ago in a hunter. This man developed a bronchitis but had a small lesion on one of his fingers which did not become an ulcer.

Dr. Snape, in discussing the treatment, said there was a two per cent mortality rate with the serum and four and five-tenths per cent without it. Death occurs from consolidation of the lung. One of the main things is good nursing care.

The fourth case report was "Pregnancy Complicated by Acute Anterior Poliomyelitis" presented by DR. FRANK J. HUGHES and DR. JOSEPH C. LOVETT.

Dr. Hughes presented the first part of the paper. This patient was twenty-three years old. She was admitted to Cooper Hospital when she started labor pains at seven months' pregnancy. The labor pains were stopped as it was felt she could carry through to full term. On second admission to Cooper Hospital, the patient was delivered of a full term, well developed baby girl six pounds five ounces. Delivery was by low forceps under light anesthesia. The baby is healthy and coming along nicely. It is rarely necessary to do a caesarean in these patients. Anterior poliomyelitis is not transmitted to the fetus by the mother. Pregnancy may increase the susceptibility to polio due to physiological strain.

Dr. Lovett in presenting the second part of the paper stated this patient was admitted to the Municipal Hospital on the third day of the disease. There was complete involvement of both legs and nearly complete involvement of both arms. She was having difficulty in swallowing and breathing and was estimated as six months' pregnant. Kenny treatment was started immediately. She became cyanotic and had to be put in the respirator. Kenny packs were continued hourly during the day while she was in the respirator. The patient responded so nicely that she was taken out of the respirator after being in four days. Respirations continued to improve under Kenny treatment out of the respirator. She had regained almost complete use of her arms by the time she was transferred to the Cooper Hospital. On her return from Cooper Hospital after delivery, she developed on her fifth day a phlebitis of the left leg.

At the present time her arms and respirations have returned to normal. She has partial return of her right leg. Her left leg has not been touched due to the phlebitis.

In the past, when we have put a patient in the respirator, they have had to remain in for several weeks. The Kenny treatment being applied while this patient was in the respirator, I feel, was responsible for her being able to be taken out in such a short time.

Dr. Shipman asked Dr. Lee, the Treasurer of the City Dispensary, to explain about the Dispensary fund which Dr. Lee felt should be transferred and kept by the County Society instead of the Dispensary. The subject is to be discussed at the next meeting.

Dr. Pratt commented on the attendance at the meetings. We should have a better attendance for the quality of the speakers that we have had. It was moved and passed that there should be another meeting of this kind to be held some time during the year.

## CUMBERLAND COUNTY

H. S. Branin, M.D., Reporter

The December meeting of the *Cumberland County Medical Society* was held December 12, 1944, at Hotel Cumberland in Bridgeton.

The usual routine business of the Society was transacted and DR. HERBERT P. ANASTER was elected to membership.

The Society was then addressed by DR. JAMES S. SHIPMAN, whose subject was "Ocular Injuries and Their Management". The paper proved very interesting and after much discussion, the Society adjourned.

## GLOUCESTER COUNTY

A. Guy Campo, M.D., Reporter

The regular monthly meeting of the *Gloucester County Medical Society* was held Thursday evening, November 16, 1944, at 9 p.m. at the First National Bank Building, Woodbury. Reporting for the insurance committee, DR. CHESTER I. ULMER specifically urged the members to subscribe to the National Casualty Company for health and accident insurance because of its advantages over other forms of insurance of similar nature.

The scientific program was started with the introduction by Dr. Ulmer of DR. EDWARD S. DILLON of the Philadelphia General Hospital Staff. His topic for the evening was "Diabetes".

The main problems encountered in diabetes, said Dr. Dillon, are:

1. Standardization
2. Complications
   a. Acidosis
   b. Gangrene
   c. Arterio-sclerotic heart disease
   d. Pyogenic infections.

Dr. Dillon stated that in general practice standardization is the more important of the two.

What to do for a true diabetic?

1. Calculate the diet. (Because it is the basis of all things.) This should be done on an average

weight of an individual for height, sex and age. An ordinary person requires thirty calories per kilogram of body weight. Let us say that an aver- person weighs 132 pounds, or 60 kilograms. That would mean 1800 calories per day. Give the patient the following proportions:

Protein, 1 gram per kilogram of body weight.

Carbohydrate, 3 grams per kilogram of body weight.

Fats, 2 grams per kilogram of body weight.

2. Whether to use insulin or not would depend on the laboratory results.

3. Discuss diabetes. Most physicians are careless when it comes to this. They should not be afraid to discuss diabetes with the patient; especially of the function of the pancreas. Some patients are afraid of needles. Therefore they must be told how trypsin destroys insulin when given by mouth, and consequently it can be given hypodermically only.

Give insulin if patient can not be controlled by diet.

In hospitalized cases diet and insulin to control diabetes is given immediately until the blood sugar is normal. Then continue or discontinue insulin, depending on the laboratory results. Insulin, when given, sometimes reactivates insulin formation in the pancreas.

Diabetic Coma—Symptoms:

1. Lassitude
2. Nausea, vomiting and abdominal pain
3. Drowsiness and coma.

Patients go into coma either because they stop their insulin of their own accord, or because of occurrence of infection either severe or mild.

Treatment of coma: Patient must be hospitalized. On making diagnosis give insulin even before hospitalization, because there is no greater medical emergency. On hospitalization treatment is as follows:

1. Insulin. Average dose is 200 units in the first four to five hours.

2. Fluids. Saline solutions for dehydration, two to three liters in the first twenty-four hours.

3. Frequent blood sugars and CO2 determinations.

4. Glucose may be needed.

5. Gastric lavage with sodium bicarbonate solution with nasal tube, to remove food.

6. Plasma. Watch the blood pressure. If it is going down give plasma, because sometimes the salt solutions do not stay in circulation; therefore the blood pressure should be taken every half hour.

Gangrene: This is very important, because financially it is a burden and costs approximately $500, which must be borne by either the patient, community, hospital or someone else. The causes behind gangrene are:

1. Patients did not know they had diabetes.

2. Eight to ten years ago they were told what to do but did not follow orders.

3. They were on a diet for one or two months, then condition cleared up, and diet was discarded. Then condition returned which led to arteriosclerosis and finally gangrene.

Arterio-sclerotic heart disease in diabetes is common. These patients run higher blood sugars than the average cases. To treat this condition, treat the diabetes.

Dr. Dillon stated that blood sugar limits are 80 to 180 mgms. Below 80 mgms. we have shock and over 180 mgms. the sugar spills over into the urine.

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The regular monthly meeting of the *Gloucester County Medical Society* was held Thursday evening, January 18, 1945, at 9 p. m. in the First National Bank Building, Woodbury.

DR. J. HARRIS UNDERWOOD spoke of cancer control in Gloucester County, stating that we have the largest contribution rate per capita in the state. He stated that we should have a tumor clinic in the county, and following discussion, it was decided a tumor clinic would be formed, possibly in the Underwood Hospital. Due to inability to staff a tumor clinic, because of shortage of physicians, we will have to forego its beginning for the duration, or until we are able to staff it.

The scientific program consisted of an illustrated talk by DR. HARRY P. BACON, Professor of Proctology, Temple Medical College, on "Practical Aspects of the Common Diseases of the Rectum and Anus".

Dr. Bacon mentioned the common conditions:

1. Petechial areas of sigmoid and chronic ulcerative proctosigmoiditis.
2. Pruritis ani.
3. Thrombotic hemorrhoids.
4. Internal hemorrhoids.
5. Fissure in ano.
6. Ischiorectal abscess.
7. Fistula in ano.
8. Malignancy of anus and sigmoid.

1. Petechial areas of sigmoid and chronic ulcerative proctosigmoiditis: Treatment—
   a. Bed rest with febrile conditions.
   b. Relaxation, physical and mental.
   c. Proper diet.
   d. Blood transfusions if necessary.
   e. Local treatment.
   f. Vitamin therapy.
   g. Vaccine, autogenous, from scraping of rectal mucosa.
   h. Sulfanilamide and sulfathiazole therapy.
2. Pruritis ani. Symptoms—itching.
   Treatment: Local—Silver nitrate and oils locally before bowel movement.
   Injections consisting of 10 c.c. 95 per cent alcohol with equal amount of 2 per cent procaine.
3. Thrombotic hemorrhoids.
   Treatment: Local anesthesia. Slit and extract.
4. Internal hemorrhoids. Injection with 5 per cent aqueous solution of quinine urea hydrochloride. Usually takes 0.8 to 1½ c.c., or until ischemia occurs. Ultimate treatment is surgical.
5. Fissure in ano. Hot sitz baths, two to three times daily; using six inches of hot water.
   Hot boric acid or witch hazel compresses continuously.
   Silver nitrate locally.
   Simple divulsion.
6. Ischiorectal abscess. Treatment—Anterior-pos-

terior incision over maximum point of fluctuation.

7. Fistula in ano. Only one treatment. Operate and remove entire area.
8. Malignancies of anum are the fourth most common in man, 78 per cent of which may be reached with index finger in rectal examination.

Early symptoms:

(1) Bleeding.
(2) Change in bowel habits
  a. Alternating between progressive constipation and diarrhea.
  b. Incompleteness of evacuation.
  c. Frequent and urgent desire for evacuation.
(3) Passage of mucus.

Late symptoms:

(1) Pain, except in sigmoid region.
(2) Loss of body weight.
(3) Odor (mephitic).
(4) Cachexia.

Diagnosis: On examination you find:

(1) Proliferation of new growth.
(2) Fixation.
(3) Degeneration and ulcer formation.
(4) Nodular condition.

Diagnosis should take into consideration history, inspection, digital examination, procto-sigmoidoscopic examination, opaque enema for x-ray, and histopathological examination.

## HUDSON COUNTY

Harry J. Perlberg, M.D., Reporter

The regular meeting of the *Hudson County Medical Society* was held on January 2, 1945, at the Masonic Club, Jersey City. Meeting called to order by DR. WALTER D. WEBER, President.

The recommendation of the Executive Committee that $3,500.00 be allocated to the Medical Economics Committee upon this sum becoming available received the approval of the Society.

The Secretary read a communication from Dr. Norman M. Scott, Secretary of the Committee on Procurement and Assignment, requesting that the members of the County Society be informed of the critical need for additional nurses for our armed services. Copy of a letter to the New Jersey State Nurses' Association containing suggestions, was also read.

A notice was read by the Secretary concerning the opening of a Nutrition Booth at Journal Square on Tuesday, January 9, 1945, under the auspices of the Jersey City Nutrition Committee, comprised of representatives of the Chamber of Commerce, American Red Cross and the Council of Social Agencies, with Dr. Louis Perkel as medical representative. The function of the booth is to provide information on food problems to the public, without cost, every Tuesday from 1 to 4 p. m. The notice contained an invitation to the members of the medical profession to attend a luncheon sponsored by the above named organizations at the Hotel Plaza on January 19.

### SCIENTIFIC SESSION

DR. LEO LOEWE, Medical Director, Brooklyn Cancer Institute of Kings County Hospital, presented an interesting and informative treatise on the subject of "Penicillin: Clinical Applications and Techniques". Discussors were DRS. ALTER, JAFFIN and NORTON. The discussion was terminated by Dr. Loewe.

## MIDDLESEX COUNTY

At the Annual Dinner Meeting of the *Middlesex County Medical Society* on December 20, 1944, the following election of officers for 1945 took place:

President—DR. W. EDGAR SHERMAN, New Brunswick
Vice-President — DR. C. HOWARD ROTHFUSS, Woodbridge
Secretary—DR. F. J. KOELSCH, New Brunswick
Treasurer—DR. W. H. MCCORMICK, JR., Perth Amboy
Reporter—DR. JOHN A. SMITH, South River

Delegate and Alternate to Nominating Committee:
Delegate — DR. JOSEPH M. GUTOWSKI, Perth Amboy
Alternate—DR. C. F. MERRILL, Highland Park

Delegates and Alternates to the 1945 House of Delegates:
Delegates (term expires in 1945)—DR. CHARLES F. MERRILL, DR. M. F. URBANSKI. Alternates—DR. P. E. DOWNING, DR. L. C. BASSETT.
Delegates (term expires in 1946) — DR. F. M. CLARKE, DR. JOSEPH H. KLER, DR. J. J. MANN, DR. WILLIAM H. MCCORMICK, JR., DR. JOHN H. ROWLAND, DR. WILLIAM C. WILENTZ. Alternates—DR. MAURICE RONA, DR. S. H. HINTON, DR. CHARLES H. CALVIN, DR. HENRY T. WEINER, DR. L. A. M. FEHER, DR. C. HOWARD ROTHFUSS.
Delegates (term expires in 1947)—DR. RALPH J. FAULKINGHAM, DR. JOSEPH M. GUTOWSKI, DR. HENRY HAYWOOD, DR. JOHN F. WEBER. Alternates—DR. PHILIP S. AVERY, DR. JOSEPH MARK, DR. F. M. HOFFMAN, DR. CHARLES W. NAULTY, JR.

## MONMOUTH COUNTY

Elsworth F. Baker, M.D., Reporter

The December meeting of the *Monmouth County Medical Society* was held at the auditorium, Borden Pavilion, Monmouth Memorial Hospital, Long Branch, on December 27, 1944, at 9:00 p.m. The Monmouth County Dental Society was invited.

The subject for the evening was "The Quality of Medical Care in Private Practice and in Compulsory Health Insurance". The speakers were STANLEY NICHOLS, M.D., Chairman of the Public Health Committee of the Monmouth County Medical Society, and EUGENE NEWMAN, D.D.S., President of the New Jersey Dental Society.

Dr. Nichols used several diagrams to illustrate his talk and emphasized the importance of formulating a program for good medical care. He stated that medical care can be considered under three groups:

1. Administrative — consisting of Public Health Departments and other Public Departments interested in health.

2. Medical Service — including Physicians, Dentists, Nurses, Pharmacists and Hospital Workers.

3. The Promotion Group — including Voluntary Agencies, Social Workers and Welfare Workers.

He stated that the majority of the cost of medical care goes to the hospitals and nursing facilities, whereas, the physicians receive only about one-fifth to one-tenth of the total cost. It is not enough that the physicians and dentists take good care of their individual patient, but as a group they must see that adequate medical and dental care is available for all. The economists emphasize the cost, quality and distribution but not the quality of medical care. Our job is to preserve quality. The more mechanical medical or dental care becomes, the more quality will suffer. The major factors affecting the quality are:

1. Medical personnel depending on the following:
   a. Under-graduate training
   b. Post-graduate training
   c. Experience
   d. Interest
2. Sufficient time per case
3. Reasonable compensation
4. Satisfactory physician and patient relationship
5. Adequate equipment
6. Red tape, that is, administrative procedure
7. The costs.

The quality of medical care in private practice will, of necessity, be greatest because, although the training and experience may be essentially the same as in voluntary health insurance, hospital and other clinics and compulsory health insurance, the interest which may be maintained in the first three types of practice will suffer under compulsory health insurance and sufficient time per case is greatest in private practice. Compensation is better and the personal relationship is best. There is the least red tape and the costs are adjusted on the ability to pay. Under compulsory health insurance this practice would attract the more poorly trained, the physician's interest is bound to lag and time per patient is definitely insufficient. Compensation is poor as is also the personal relationship, whereas the red tape of administrative procedure is tremendous.

Dr. Nichols stated that the medical profession should strive to improve the factors entering into the medical care in private practice, voluntary health insurance and the various clinics. The quality of medical care in compulsory health insurance cannot be improved as the major factors affecting it are largely unchangeable.

Dr. Newman stated that in Monmouth County the dentists had started a free clinic in the schools but found that the people would not attend it as they did not want free dental service. The personal relationship was important. He stated that he was disappointed that the physicians and dentists were not more interested in their organizations and felt that much could be done if they would support their local organizations and work together as a unit in talking over their problems and evolving a system of educating the people through the schools. He stated that they should agree on a policy for the various income groups and that the dentists and physicians should coöperate more closely.

Lawrence R. Burdge, D.D.S., stated that it was necessary to educate the people as to the advantages of private practice; that they definitely do not want free clinics and the dentists have already worked out a plan in New Jersey for the care of the indigent. The names of certain dentists are submitted by the Society and hours are given for the care of these patients who are brought into their offices. The quality of this dental care is stressed. He believes that no better plan can be offered by any group than the dentists already have in practice. It offers the personal relationship, giving sufficient time per patient and costing the least of any plans. Local agencies are used to declare the indigency of the patients who contribute what they can toward the cost. The remainder of the funds are supplied by Public Health Funds.

Lieut. Commander William Heatley, who has recently returned on leave from the South Pacific, was welcomed back to the Society. He showed numerous Japanese souvenirs which he had brought back with him.

## PASSAIC COUNTY

J. Reuben Budd, M.D., Reporter

The regular meeting of the *Passaic County Medical Society* was held at the Board of Freeholders' Room in the Administration Building in Paterson on December 19, 1944. The meeting was called to order by the President, Dr. William Sullivan.

Dr. Sullivan introduced the speaker, Dr. Harry Gold, Associate Professor of Pharmacology at Cornell University Medical School, whose subject was "Penicillin". Dr. Gold discussed briefly the history of the drug, emphasizing the accidental discovery by Professor Alexander Fleming, at St. Mary's Hospital, London, when he observed that staphylococcus colonies surrounding a large colony of contaminating mold had become transparent and obviously were undergoing lysis. The relative lack of interest following Fleming's first article in the June, 1929, issue of the British Journal of Experimental Pathology was surprising. However, more recently clinical interest was stimulated by the Oxford workers under the leadership of Chaen and Florey. Dr. Gold spent considerable time on the significance of the unit, revealing that pure crystalline penicillin contains 1650 units per milligram and the usual commercial product contains 1650 units per milligram. Comparisons between the sulfonamides and penicillin were made. The method of action, mode of administration and dosage were made clear by lantern slides. The interesting subject of drug fastness was pointed out.

Dr. Gold is an excellent teacher and after attending any of his talks one leaves with the satisfaction of having learned something from an authoritative source.

At the business meeting which preceded the talk by Dr. Gold, resolutions were read on the deaths of Drs. Stinson, Kuhl and Temple.

The following applications were voted on and accepted: Active Membership—Dr. Harry Katz, Paterson, and Associate Membership—Dr. William MacGahan of Pompton Lakes. The Society also voted to suspend Dr. Joseph B. Polizzotti from membership for a period of six months.

# WOMAN'S AUXILIARY

## PRESIDENT'S MESSAGE

Mrs. David B. Allman

As I visit the various component County Societies I am happy to see such splendid work being done by so many. But much more could, and should be accomplished.

The 1944 elections have swept away every hope that the free and private practice of medicine will not be replaced by a system of state medicine unless all of us who are interested in the welfare of the public and in the well being of organized medicine do our utmost to prevent this national catastrophe.

The first successful regimentation of any group means the end of free government. It is incumbent upon us, the relatives of physicians, to help prevent the imminent regimentation of medicine.

We can be of great assistance to The Medical Society of New Jersey by becoming better informed on the pros and cons of state medicine, and to spread our knowledge among those other groups with whom we associate.

A few women in a few counties are not enough. We must present a united front, and although the President of The Medical Society of New Jersey, and the Chairman of Organization of the Woman's Auxiliary are doing all in their power to bring into our fold the few remaining counties that have no Auxiliary, I feel it my duty at this time to make a personal appeal to all physicians in any county where a Woman's Auxiliary to the Medical Society does not exist, to use their influence toward a speedy organization of the women in their county. Much can be done by our Auxiliaries along educational lines to inform the public of the catastrophic effects of state medicine. We must not feel that "it can't happen here". Certain powerful labor groups demand socialized medicine. We must prevent it by having an informed public.

Our consideration of this problem is paramount at this time, and I ask the help of every County Auxiliary as well as every individual member toward that end.

## LEGISLATION

Mrs. M. L. Weimann, Chairman

Medicine in the United States is indeed at the "crossroads". With labor leaders clamoring for socialization it is up to the medical profession to prove the merit of our present system and to supply from within any changes that may be necessary. Then and only then will governmental changes be unnecessary.

How can we, as members of the Auxiliary to The Medical Society of New Jersey, aid this cause? First we can educate ourselves so that we will be able to speak with authority when confronted with opposing views. If we know the facts involved we can be sure of our answers. It is our very uncertainty that gives credence to the views of our opponents. Let us study both sides of the argument. We do not agree but we must try to understand, because understanding of the other point of view is necessary for refutation of it.

If possible, present a forum discussion at one of your meetings. This forum would present four subjects. First, the need for socialized hospitalization, as presented by C. I. O. leaders, social workers, educators, etc. Second, the answer to this need in the form of hospitalization insurance. Third, the need for Socialized Medicine, from the same sources. Fourth, the answer to this need, in the form of insurance for catastrophic medical and surgical care. The Medcial Society of New Jersey, as are the medical societies in many of our states, is providing us with a constructive program for medical, surgical, and hospital care. We must be informed about it so that we may, in turn, inform others.

In any discussion we must admit that we also, as members of physicians' families, are interested in the social and economic security of each individual in our great country. We recognize that this security is desirable and even necessary to the welfare of our country as a whole. We must also admit a purely selfish motive in the desire to perpetuate a system of medicine, advantageous to both patient and doctor. We must stress the danger of moving forward so rapidly in social gains that

our democratic government, with its rights of the individual, will be jeopardized. Hence, we hope for an evolutionary method of change which will insist upon the continuance of free choice on the part of patient and physician while supplying adequate medical care to all individuals at all times.

The Wagner-Murray-Dingell Bill, as we knew it, is dead, but let us not be lulled by any false sense of security. Another similar bill will be forthcoming. Let us be prepared for it and ready to receive it. Watch for the report of the Pepper Committee! The next bill may be very similar. Prepare your busy doctors for it. Keep them informed at all times. Keep your friends informed so that they may also voice their disapproval of any changes which may be too radical. If we all take the time and make the effort to tell our legislators what we wish we may still be heard and a great mistake may be averted. Let us not be caught "napping"! This is our opportunity; it is more than that—it is indeed our challenge!

## FUTURE EVENTS

Camden—Plans are going forward in the Woman's Auxiliary to the Camden County Medical Society for a Fashion Show and Card Party to be held at the Walt Whitman Hotel Monday evening, February 26, 1945. There is to be a Junior and a Senior Fashion Show. Mrs. Oram R. Kline is the general chairman and Mrs. George B. German is her co-chairman.

On March 13, 1945, the Woman's Auxiliary will hold its annual Public Relations tea in the Camden Woman's Club, 424-26 Linden Street, to which are invited representatives of all the woman's organizations throughout the county. Mrs. A. Haines Lippincott will be the chairman of the program.

Essex—There will be a regular Board meeting of the Woman's Auxiliary to the Essex County Medical Society at the Academy of Medicine at 11 a. m. on Monday, February 26, 1945. At 12:30 dessert and coffee will be served to all the members of the Auxiliary. Business meeting at 1 p. m. Program at 2:30 p. m. The speaker of the afternoon will be Miss Frances Church, a representative from Elizabeth Arden, whose subject will be "The Cultivation of Beauty".

Gloucester—A regular business meeting of the Woman's Auxiliary to the Gloucester Medical Society will take place at the home of Mrs. H. B. Diverty at 9 p. m., Thursday, February 15, 1945.

## EXECUTIVE BOARD MEETING

Mrs. Lodovico Mancusi-Ungaro, Chairman, Press and Publicity

A meeting of the Executive Board of the Woman's Auxiliary to The Medical Society of New Jersey was held on Monday, January 8, 1945, at the elegant new home of The Medical Society of New Jersey, Trenton. Mrs. David B. Allman, Auxiliary President, presided.

Following a business session in the morning those present were guests of the Auxiliary at buffet luncheon.

In the afternoon Dr. Norman M. Scott, Medical Director of Medical Service Administration and Executive Vice-President and Medical Director of Medical-Surgical Plan of New Jersey, spoke to the Auxiliary.

Preceding his main address of the afternoon Dr. Scott made a very earnest and sincere plea for our coöperation in promulgating the recruitment of nurses. The situation at this time is desperate. The wounded are landing at the rate of 30,000 a month and at the Halloran General Hospital the ratio of the nurses to the patients is one to one hundred. Never has a professional group failed to heed the call of duty, and we who are associated so closely with an allied profession should assist in this program.

Dr. Scott said that the medical care problem in New Jersey is an economic problem, and in its solution we must break down the economic barrier which sometimes exists between patient and physician. Medical care of the indigent and medically indigent is a joint responsibility of the physician and government. Medical care of self-supporting em-

ployed persons must be a responsibility of the individual who must assume responsibility for his own welfare and that of his dependents in accordance with democratic principles.

A program for the solution of this problem is now in operation as sponsored by The Medical Society of New Jersey, which includes the Farm Security Plan, the Newark City Plan and the Medical-Surgical Plan. The program is built upon the framework of the best methods of medical practice, adjusted to the needs of various economic groups and providing free choice of physician and patient, and non-interference with patient-physician relationship.

## AUXILIARY REPORTS

### Atlantic County

Mrs. Samuel Salasin, Chairman of Publicity

The *Woman's Auxiliary to the Atlantic County Medical Society* and the wives of the Army and Navy Medical Corps officers stationed in that area enjoyed a Christmas musicale and party held at the home of Mrs. James H. Mason, 3rd, during the Christmas holidays. A group of songs were sung by Mrs. Thomas Petinga. Mrs. E. G. Shreve, mother of Mrs. Mason, portrayed a very jolly, lovable Santa Claus and presented each guest with a white elephant gift with appropriate comments on each. Gifts were brought by the members for the children in the Betty Bacharach Home.

On January 2, 1945, members of the Atlantic Auxiliary delivered cookies to the Atlantic City Chapter of the American Red Cross to be sent to soldiers returning for furloughs on January 3rd.

On Monday, January 15, 1945, Mrs. Daniel C. Reynor, President of the Atlantic Auxiliary, presided at the regular meeting and luncheon held at the Madison Hotel. Mrs. Samuel Salasin was chairman of arrangements for the day. Mrs. Reynor and Mrs. Allman gave resumes on the talk given by Dr. Norman M. Scott at the January 8th meeting of the Executive Board in Trenton.

### Camden County

Mrs. Lawrence L. Glover, Publicity Chairman

The meeting of the *Woman's Auxiliary to the Camden County Medical Society* was held on January 3, 1945, at the home of the President in Camden. Colorful holiday decorations provided a gay and festive atmosphere for this Christmas meeting. The business meeting was presided over by Mrs. Thomas P. McConaghy.

Plans were made to attend the luncheon meeting of the Executive Board of the State Auxiliary held on January 8 in Trenton.

Mrs. Harold D. Barnshaw, one of our own members, has returned to her home in Camden County and she presented a thoroughly delightful talk on "The Experiences of a Navy Doctor's Wife". She reviewed the itinerary of a Navy doctor's family; their methods of travel, their varied housing problems, the inconveniences of moving a small family, one member of which is still a baby. It seems that Navy wives are able to cope with almost any situation that arises and still keep pace with the shifting Navy personnel, who may be here today, in the South next week and soon thereafter on the West Coast.

Following this charming presentation, Miss Marion Meany played several piano selection and tea was served. Mrs. E. Reed Hirst and Mrs. A. Gomersall Pratt poured.

### Essex County

Mrs. Rocco Marra, Chairman of Publicity

Culminating the drive for members, Mrs. Don Epler and Mrs. Irving J. Berney, Chairmen of Membership for the *Woman's Auxiliary to the Essex County Medical Society,* held a tea for prospective members at the Academy of Medicine on December 15, 1944.

Nine hundred invitations were sent out: 300 to our own membership and 600 to the Essex County Society members' wives who do not belong to the Auxiliary. Refreshments were solicited from the members by the chairmen of membership for the occasion. Mrs. Louis Schneider, wife of the President of the Essex County Medical Society, and Mrs. Harry Comando, Junior Past-President of the Auxiliary, presided. About 70 were present.

Twenty new members have already been enrolled, and more than 50 have written in saying that they were interested.

A joint meeting of the Essex County Medical Society and the Woman's Auxiliary to the Society was held Thursday, January 11, 1945, at 9 p.m. at the Academy of Medicine.

The guest speaker of the evening was Major Donald Covalt, M.C., AAF Surgeon. Major Covalt described the newer methods of convalescent training which make up the program followed in AAF hospitals. Convalescent hours are devoted to a program which includes physical training, military and general education, psychological readjustment and resocialization of the patients, Major Covalt explained. Men are frequently sent out of the hospital in better general condition than before they entered for treatment of wounds or disease, the speaker added. Through the new methods the period of recovery is shortened and readmissions for hospital treatment are reduced. As an example of more rapid and satisfactory recovery, Major Covalt told of a study of 645 cases of primary atypical pneumonia in two parallel groups. The group allowed to convalesce in the old routine manner averaged 45 days of hospitalization with a 30 per cent

recurrence rate. Those participating in the convalescent training program averaged 31 days of hospitalization with a 3 per cent recurrence. Accentuating the program's feature of treating each patient as an individual, the speaker said each man is assigned to one personal physician who takes the place of a "family doctor" during hospitalization. Motion pictures were shown illustrating methods used in convalescent hospitals, beginning with counseling the patient, showing the early physical training leading up to outdoor sports, and manual training.

The meeting was presided over by the President, Dr. Louis Schneider, who introduced the speaker.

A collation was served after the meeting by our hostess committee.

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### Gloucester County

Mrs. C. A. Bowersox, Chairman, Press and Publicity

The *Woman's Auxiliary to the Gloucester County Medical Society* held its regular business meeting at the home of the President, Mrs. H. B. Diverty, Cooper Street, Woodbury, on December 21, 1944.

Minutes of the previous meeting were read by Mrs. Guy Campo in the absence of the Secretary, Mrs. William Pedrick. The Treasurer's report was received by Mrs. William Harris.

A legislative report was given by Mrs. Chester Ulmer.

There were eight members present.

Refreshments were served following the meeting.

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### Mercer County

Mrs. C. Chester Chianese, Chairman of Publicity

The *Woman's Auxiliary to the Mercer County Medical Society* held a meeting on January 8, 1945, at the Executive Offices of the State Society. Mrs. H. Donald Cowlbeck, President, presided.

The President took this occasion to report that she had represented the Auxiliary at the Christmas party held at the Donnelly Memorial Hospital on December 19, 1944.

At a meeting of the Women's Aide for the Donnelly Hospital on November 16, 1944, at City Hall, it was decided that various Trenton organizations would take the names of some patients and send a bit of Christmas cheer. The Auxiliary wrapped and tagged 28 gifts, consisting of dusting powder, handkerchiefs, fancy soaps, hard candies, cigarettes and tobacco.

On the set date, Presidents of many societies were guests at a dessert luncheon at the home of the chairman, Mrs. Mary G. Roebling, of West State Street. Immediately following, the assembled group went directly to the hospital to continue with the program. A jolly Santa Claus distributed the load of gifts and a professional magician, a dancer and a singer entertained most elaborately. A merry time was enjoyed by all.

The Auxiliary was happy to be a member of this Committee—making hearts lighter. This was a day well spent indeed.

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### Middlesex County

Mrs. Norman Rosenberg, Chairman of Publicity

On December 20, 1944, the *Woman's Auxiliary to the Middlesex County Medical Society* met at the home of Mrs. Robert Walker in Highland Park. A Board meeting was held at 7:30 p.m. followed by a social evening of cards, games and a grab bag. Each member contributed a Christmas box for a hospital patient at Camp Kilmer. Mrs. Charles Merrill, President, presided, and Mrs. Norman Forney and Mrs. William Condon were in charge of the refreshments for the evening.

On Wednesday, January 17, 1945, the Auxiliary sponsored an open meeting on the control of cancer at the auditorium of the Middlesex Hospital. Presidents of the women's clubs of the community were asked to invite members and the meeting was open to the public. The speaker of the evening was Mrs. A. Haines Lippincott of Camden, Commander of the New Jersey Field Army of the American Society for the Control of Cancer. The title of her talk was "A Message of Hope". Mrs. Norman Forney, Jr., was the chairman of the arrangements, assisted by Mrs. William Condon and Mrs. Norman Rosenberg.

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### Passaic County

Mrs. Irving Silverman, Chairman of Publicity

The *Woman's Auxiliary to the Passaic County Medical Society* held its first meeting of the new year January 15, 1944, at the home of Mrs. Richard J. McDonald, 777 Fourteenth Avenue, Paterson, the Chairman of the Advisory Board. Mrs. Joseph E. Mott, President, presided.

Interesting reports were given by the chairmen of various committees, as follows: Mrs. Irving Silverman, Press and Publicity; Mrs. H. H. Hollingsworth, Legislation, and Mrs. Alfred D. Meneve, Bulletin.

Mrs. Mott appointed Mrs. A. M. Schultze Chairman of the Camp and Hospital Committee.

Three new members, Mrs. William B. Ruocco, Mrs. Richard White and Mrs. Irving Chrisman, were introduced.

Guests at the meeting were the State Auxiliary President, Mrs. David B. Allman of Atlantic City, who gave an inspiring talk on the work of the Auxiliary; Mrs. William E. Dodd of Beach Haven, President-Elect of the State Auxiliary, and Mrs. Don A. Epler, State Parliamentarian.

Following the business session a delightful piano recital was given by Mrs. Milton Boyd.

A tea and reception to honor new members who have joined the Auxiliary since last January concluded the afternoon's program.

## BOOKS RECEIVED FOR REVIEW

Lead Poisoning. By Abraham Cantarow, M.D., and Max Trumper, Ph.D. Pp. 264. Baltimore, Williams & Wilkins Company. 1944. $3.00.

Manual of Clinical Mycology. Prepared under the auspices of the Division of Medical Sciences of the National Research Council. Pp. 348 with 148 illustrations. Philadelphia & London, W. B. Saunders Company. 1944. $3.50.

Pathology of Internal Diseases. By William Boyd, M.D., LL.D., M.R.C.P., Ed., F.R.C.P. London. Dipl. Psych. F.R.S.C. 4th ed. Pp. 857 with 366 engravings and 8 colored plates. Philadelphia, Lea & Febiger. 1944. $10.00.

Story of a Hospital: The Neurological Institute of New York, 1909-1938. By Charles A. Elsberg, M.D. Pp. 174. New York, Paul B. Hoeber, Inc. 1944. $3.50.

(The) Avitaminoses; the Chemical, Clinical and Pathological Aspects of the Vitamin Deficiency Diseases. By Walter H. Eddy, Ph.D., and Gilbert Dalldorf, M.D. 3d ed. Pp. 438, illustrated. Baltimore, Williams and Wilkins Company. 1944. $4.50.

Clinical Heart Disease. By Samuel A. Levine, M.D., F.A.C.P. 3d ed. Pp. 462 with 157 illustrations. Philadelphia & London, W. B. Saunders Company. 1945. $6.00.

Patients Have Families. By Henry B. Richardson, M.D., F.A.C.P. Pp. 408. New York, The Commonwealth Fund. 1945. $3.00.

American Medical Practice in the Perspectives of a Century. By Bernhard J. Stern, Ph.D. Pp. 156. New York, The Commonwealth Fund. 1945. $1.50.

## BOOK REVIEWS

**The Boy Sex Offender and His Later Career.** By Lewis J. Doshay, M.D., Ph.D., with a foreword by George W. Henry, M.D. Pp. 206. New York, Grune & Stratton. 1943. $3.50.

The sex problems of male children, including high school age, are dealt with in this small, well-written volume. Among the causes are the influence of environment, religious training or lack of it, heredity, too many motion picture shows, lack of the right kind of parental care, school maladjustments, neurological and physical defects, and temperament. All causes are discussed as are the treatment by courts and institutions.

The teaching of sex in high schools beginning with biology and including marine and plant life, is thoroughly discussed.

The book is recommended to teachers, superintendents of children's homes, social workers, legislators and court officials. It is a challenge to our social order which should lead to an improvement in ethical culture and moral standards.

Louis Simonson, M.D.

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**The Treatment of Peptic Ulcer,** based upon ten years' experience at the New York Hospital. By George J. Heuer, M.D., assisted by Cranston Holman, M.D., and William A. Cooper, M.D. Pp. 118. Philadelphia, J. B. Lippincott Company. 1944. $3.00.

Dr. Heuer and his associates have presented an interesting study of the treatment of peptic ulcer between September 1, 1932, and December 31, 1941, at the New York Hospital and Cornell University Medical College.

The authors are in accord with the principles of adequate medical treatment for uncomplicated ulcer but believe that there sometimes may be a delay in surgical treatment of patients who do not respond promptly to this medical treatment and found that their highest mortality from hemorrhage and perforation occurred during the first year of follow-up after medical treatment.

Their conclusions regarding gastro-enterostomy are interesting although they may not be shared by the majority of surgeons doing a large amount of gastric surgery. They claim "the result of gastro-enterostomy as compared with those of gastric resection are better than many of our staff have supposed. They approach within 10 per cent those of resection; and with a lower primary mortality rate." The authors question whether gastric resection brings about a great reduction of gastric acidity, either relative or absolute, as compared with gastro-enterostomy. A thorough digestion of this monograph, particularly the discussions and summaries, will be worth any surgeon's time.

C. A. Beling, M.D.

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**Essentials of Pharmacology and Materia Medica for Nurses.** By Albert J. Gilbert, M.D., and Selma Moody, R.N. Second Edition. C. V. Mosby Co., St. Louis. 1944. Price $2.50.

Considerable revision has been made in this edition to include the newer clinically useful drugs such as penicillin, latest sulfa derivatives, diethyl stilbestrol, evipal sodium, adrenal cortex extract, aluminum hydroxide gel and crystalline zinc insulin. Changes have also been made to conform with latest editions of the *U. S. Pharmacopoeia, National Formulary* and *New and Nonofficial Remedies.* Facts and theories of pharmacology and materia medica are presented to nurses in a lucid, concise form, adopted to nursing school courses. The plan of the book follows in general the outline of the "Curriculum Guide for Schools of Nursing" prepared by the National League of Nursing Education. Chapters are terse, clearly illustrated and well indexed for quick reference. New chapters have been added on prescription reading and toxicology. The appendix contains doses of important drugs, common Latin abbreviations, tables and suggested questions for study. Not a large book but a most compact and useful one for the nurse.

Carolyn Valentine, B.S.

**Technique in Trauma, Planned Timing in the Treatment of Wounds Including Burns,** from the Montreal General Hospital and McGill University. By Fraser B. Gurd, M.D., C.M., and F. Douglas Ackman, M.D., C.M., in collaboration with John W. Gerrie, M.D., C.M.; Joseph E. Pritchard, M.D.; Edward S. Mills, M.D., C.M., and Frederick Smith, M.D. Preface by John S. Lockwood, M.D., with commentary by Ralph R. Fitzgerald, M.D., C.M. Pp. 68, illustrated. Philadelphia, J. B. Lippincott Company. 1944. $2.00.

The presentation of this monograph on trauma is timely and well done. It consists of papers originally appearing in the Annals of Surgery pertaining to the treatment of major and minor burns, timing and treatment of wounds, the use of occlusive compression dressings with sulfathiazole emulsion, and added commentary by Ralph R. Fitzgerald in the form of questions and answers.

The principles outlined in these papers are sound and speak for themselves. The efficacy of prompt treatment of burns, including replacement therapy, compression dressings with sulfathiazole emulsion or other circumstances followed by area skin grafting may be attested by more and more serious workers in this field, whose principles are fundamentally alike and whose practice differs but slightly in the employment of the appropriate medium.

Great changes are taking place in our treatment of burns and from them should evolve vastly superior results. We are still in the period of change.

C. A. BELING, M.D.

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**Simplified Diabetic Management.** By Joseph T. Beardwood, Jr., A.B., M.D., F.A.C.P., and Herbert T. Kelly, M.D., F.A.C.P. 4th ed. Pp. 172, illustrated. Philadelphia, J. B. Lippincott Co. 1944. $1.50.

For the layman this book gives a fairly detailed account of the physiology of diabetes. Of particular interest is the description of the "unit" system for calculating the diet. Perhaps if one gets accustomed to this system it will be of help, but to one who is used to the ordinary methods it might seem to add to the arithmetical burden.

The pages on vitamins and other food values, and the suggested menus will be helpful. This manual should prove useful to the intelligent diabetic patient.

LOUIS GRUNT, M.D.

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**Manual of Military Neuropsychiatry.** Edited by Harry C. Solomon, M.D.; Paul I. Yakovlev, M.D., and others. Pp. 764. Philadelphia, W. B. Saunders Co. 1944. $6.00.

The work of forty-five well-known neuropsychiatrists is incorporated in this pocket-size manual, which is not only compact in size but is also comprehensive and readable. The editors have done an excellent job in arranging the material which starts with a brief account of neuropsychiatric experiences of the First World War and then carries through with an outline of induction station structure and examinations, the mechanics of administration and disposition of neuropsychiatric casualties and a very usable section on the more common neuropsychiatric conditions.

The section on prophylaxis and therapy is particularly practical and the final section on special topics such as neuropsychiatric aspects of convoy and torpedo casualties, the physiology of flying and a diagnostic evaluation of electroencephalography contains much that is interesting.

The book is written in such a style that it will be useful to physicians at home who have "psychiatrically unfit" service men to care for. As a manual for the physicians in service it is indispensable.

JOHN W. KINLEY, M.D.

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**Diagnosis and Treatment of Acute Medical Disorders.** By Francis D. Murphy, M.D., F.A.C.P. Pp. 503. Philadelphia, F. A. Davis Co. 1944. $6.00.

Dr. Murphy seems to have adopted a style of writing, the art of which disappeared with Osler. He writes in an easy manner, removing the usual orthodox scientific data in such a way as to make the book one that can be picked up when seeking information and retaining the knowledge which has been expressed in simple style. His treatise on cardiac pathology is nicely defined. The treatment is up to date and evidently considerable thought and study has been given to medication.

The book also discusses tropical diseases in a competent manner as well as acute poisonings with treatment well outlined.

This is the type of book that a student or practitioner would desire to keep on his desk for frequent perusal rather than place in his library to consult on rare occasions. When one desires the required information without spending time reading considerable unnecessary samples of printer's ink, this is the volume to consult. It is a book worthy of its title, is well indexed and a lot of material has been condensed in its 503 pages.

THOMAS M. PASCALL, M.D.

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**Collected Papers of the Mayo Clinic and the Mayo Foundation.** Ed. by Richard M. Hewitt, B.A., M.A., M.D.; A. B. Nevling, M.D.; John R. Miner, B.A., Sc.D.; James R. Eckman, A.B., and M. Katharine Smith, B.A. v. 35. Pp. 875 with 208 illustrations. Philadelphia & London, W. B. Saunders Company. 1944. $11.00.

As usual, the annual volume of collected papers from the Mayo Clinic is a welcome addition to medical literature containing, as it does, so many worthwhile articles on so many varied subjects.

Of particular interest are papers on prognosis of carcinoma of the stomach as estimated by grading, esophageal pain, diet in relationship to hepatic physiology and pathology, the management of ulcerative colitis, advances in the knowledge of coronary sclerosis, sympathectomy for hypertension and its physiologic aspects, protrusion of intervertebral discs, continuous caudal anesthesia and several articles on the use of penicillin.

The reviewer wishes to call attention to two other papers entitled "The Medical Care of Executives" and the "Value of Research in Medical Education".

C. A. BELING, M.D.

# Tuberculosis Abstracts

## *A Review for Physicians*

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

**Vol. XVIII** **February, 1945** **No. 2**

TUBERCULOSIS among older people remains one of the stubborn pockets of resistance in the general campaign aimed at the eradication of the disease. For the most part we must rely upon the general practitioner to carry out this phase of the struggle, for the individuals concerned are usually among his patients and outside the range of the present "mass" control measures.

## TUBERCULOSIS IN ELDERLY PEOPLE

The importance of tuberculosis in elderly people, especially pulmonary tuberculosis, has been generally underestimated. One reason for this is that few of us have any conception of the number of older people among us. There are in the United States nearly four thousand persons over 100 years old; over 87 thousand who are past 90; more than one million who are over 80; more than five million over 70; and 13.5 million over 60. These, with 13 million in their fifties, make a total of over 26.5 million persons over 50, more than 20 per cent of the whole population.

The U. S. Census figures for 1870 showed only about 11 per cent of the population over 50 at that time. A reduction in mortality from infectious disease, increased application of sanitary science, better housing and nutrition are all contributing to the longer life of the present day. How permanent the present large percentage of older people in the population will be, we cannot tell. Continued wars followed by widespread epidemics, may again reduce life expectancy to that of the middle ages.

Now, however, when about one fifth of our population is elderly, it is important that we know how much of it harbors tuberculosis, and how much of a menace to the community this represents. Is tuberculosis in the later decades of life increasing?

Figures from the U. S. Census Bureau show that the mortality rates from tuberculosis in the United States in 1940 were much higher in the later decades of life than among young people. The highest rate in 1940 at any age period, that of males between 55 and 65, was 110 per 100,000. In 1900 the highest rate for males, 362 per 100,000, was in the age period, 35 to 39.

The death rate from tuberculosis is still relatively high in persons over 50, and since this group forms about 20 per cent of the population, there are many elderly tuberculous persons in the country. Using the very conservative factor of five active cases for every death, the active cases, many of which are spreading infection, may be estimated as at least 100,000. Not all of these cases are in sanatoria.

### Pathology

There has been a great deal of controversy regarding the seriousness of tuberculosis in old people. Some have considered it relatively benign, while others have thought it rapidly progressive. In one report of a series of 142 cases over 55 years of age admitted to a sanatorium, many of the patients had active tuberculosis with positive sputum for periods of from 10 to 40 years. The number of tubercle bacilli eliminated by sputum-positive cases which remain positive for periods as long as 10, 20, 30 or 40 years, can only be faintly realized or comprehended, in this respect being comparable only to national expenditures for war and other purposes.

The patients in sanatoria are for the most part those with active or progressive lesions. Probably a large proportion of the fibrotic cases with few symptoms are at home. This circumstance makes it difficult to determine the typical characteristics of pulmonary tuberculosis as it affects elderly people.

Aging tissues are said to be less susceptible to inflammatory processes than growing ones, and tend to develop fibrous change. Obliteration of

lymphatic channels and involutional changes take place which may render the body resistant to the spread of tuberculosis. On the other hand there is probably concomitant atrophy, decalcification and dehydration. A few individuals may reach old age without previous infection and develop primary tuberculosis, not always distinguishable clinically from reinfection tuberculosis.

Many elderly persons who have definitely recognizable tuberculous lesions with positive sputum have become somewhat immune to the toxic effects of their disease, and make up a highly infectious class. In this group are included the so-called "good chronics" with positive sputum who do not consider themselves ill. Some of them care for young children or are otherwise in close contact with susceptible persons.

The course of events in any individual case is dependent not only on exposure to fresh infection or on the reactivation of old quiescent foci, but also on the endowment of the individual with more or less resistant tissues. Although tuberculosis may only become manifest and troublesome in later life, its origin usually is to be sought in an earlier period.

## Differential Diagnosis

While tuberculosis is relatively common in later life, its detection is frequently difficult. Diseases likely to cause confusion are frequently met. Included among them are cancer, cardiovascular disease, chronic bronchitis, emphysema, bronchiectasis, asthma and silicosis. If the sputum does not contain tubercle bacilli, the differentiation becomes increasingly difficult. Cough, weakness, loss of weight, hemoptysis and other symptoms found in tuberculosis may be present in other conditions with consequent difficulty in differential diagnosis.

Many cases of tuberculosis in older people are not detected because few of them have had chest X-rays. Most of the surveys have been among children and young people who are much more easily persuaded to coöperate. It has been difficult to secure the consent of older people for examination. They pay less attention than young people to declining health, which they feel is to some extent inevitable. Their tired feeling they consider a normal accompaniment of old age. They do not like to change their environment and are fearful lest there may have to be radical alterations in their way of living. Inertia and dread of loss of security make them hesitate.

Methods of search for unsuspected cases of tuberculosis, however, are changing. The X-ray, our most valuable resource for this purpose, is being used more freely since it is becoming less expensive. An X-ray of the chest will soon be part of the routine examination of all patients seen by physicians in their offices, just as it is now becoming a part of up-to-date clinic practice.

## Treatment

The treatment of tuberculosis in old people is in many respects the same as it is for those in early life. Rest of the inflamed area is the keynote and will probably be necessary even if some day some form of chemotherapy is found. Certain difficulties in the rest treatment of elderly patients are apparent. Complete immobilization is not well borne by the aged and mechanical measures to secure lung rest are less applicable for them. Symptomatic treatment and good nursing may bring good results where mechanical adjuncts to bed rest are not advisable. Exceptional cases will doubtless have to remain at home. The physician should, however, not accede to such a plan without a full realization of the risks involved, and the possibility of infecting an entire family and a new generation.

The entire population needs and deserves good medical supervision. Persons with arrested tuberculosis, in order that they may be kept from reactivating their lesions and becoming spreaders of tubercle bacilli need more than the average medical attention. Older persons in this category will require as much consideration and follow-up as younger patients.

*Tuberculosis in Elderly People, A. T. Laird, M.D., The Journal-Lancet, June, 1944.*

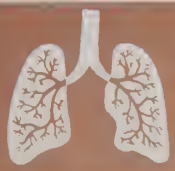
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1. Sperling, L., Weisman, S. and Papermaster, R.: Surgery, *11*:600-604 (April) 1942.
2. Boyer, N. H.: J.A.M.A., *122*:306-309 (May 29) 1943.
3. McMahon, A. and Nussbaum, R. A.: So. Med. Jl., *33*:1127 (Nov.) 1940.

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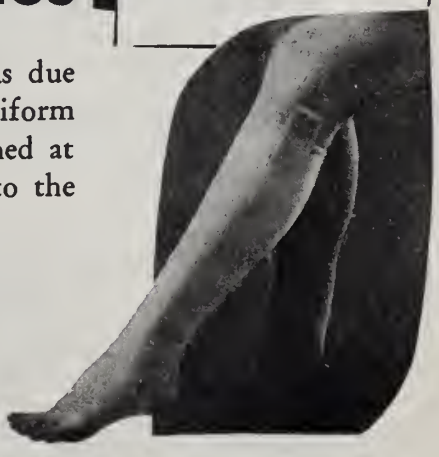
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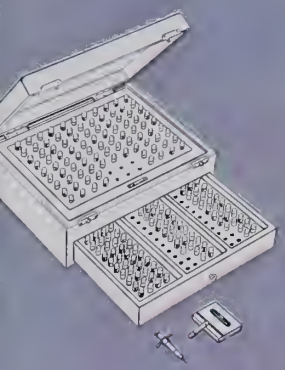
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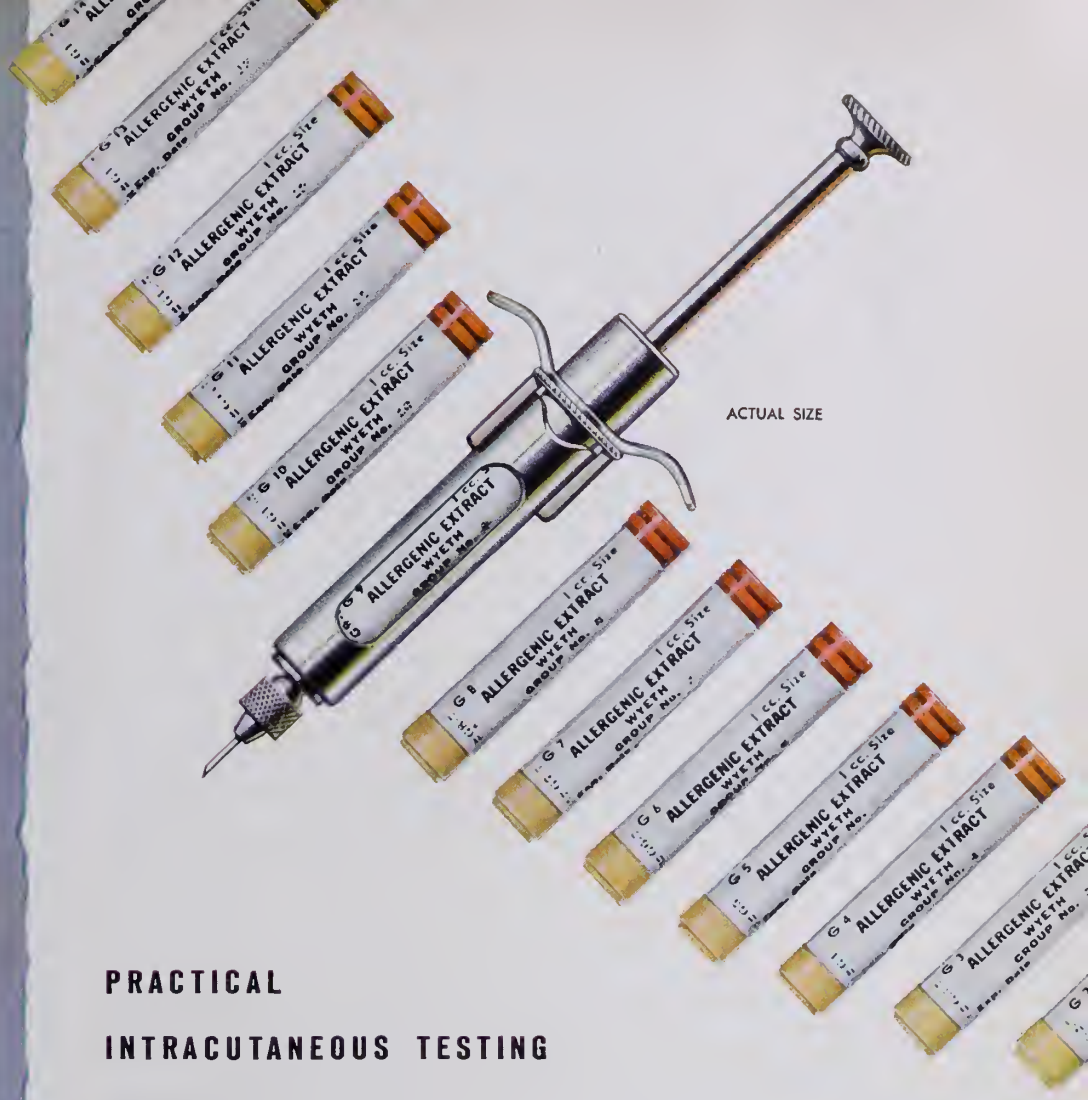
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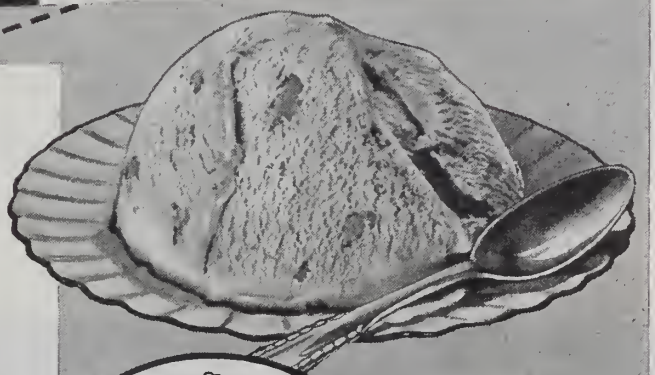
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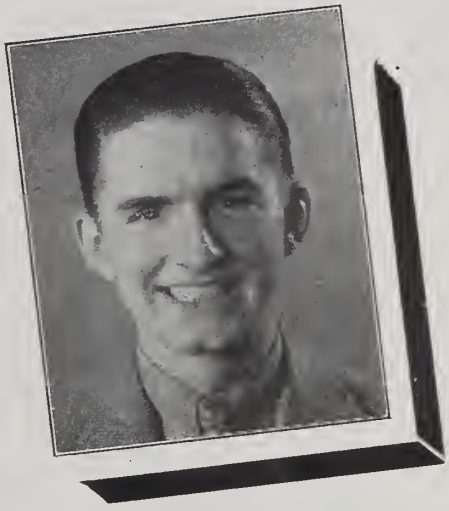
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*"Pleasing Particular People for Over Forty Years!"*

# FEWER nocturnal insulin reactions



When diabetics use 'Wellcome' Globin Insulin with Zinc, nocturnal hypoglycemic reactions are minimized. The action of Globin Insulin is greatest during the first fifteen hours and gradually diminishes thereafter.

For the patient, this means that maximum insulin activity occurs during the hours of food ingestion and greatest carbohydrate metabolism. By the time insulin requirements are lessened, as in leisure evening hours and sleep, the activity of Globin Insulin ordinarily diminishes sufficiently to avoid reactions.

'Wellcome' Globin Insulin with Zinc is intermediate in action between quick-acting short-lived regular insulin and slow-acting long-lived protamine zinc insulin. It is a clear solution, and in its freedom from allergenic properties, is comparable to regular insulin. It is accepted by the Council on Pharmacy and Chemistry, American Medical Association, and was developed in the Wellcome Research Laboratories, Tuckhoe, New York. U. S. Patent No. 2,161,198. Available in vials of 10 cc., 80 units in 1 cc. 'Wellcome' Trademark Registered

ACCEPTED AMERICAN MEDICAL ASSN Council on Pharmacy and Chemistry

'WELLCOME'
GLOBIN INSULIN
WITH ZINC

*Literature on request*

BURROUGHS WELLCOME & CO. (U. S. A.) INC. 9-11 East 41st Street, New York 17, N. Y.



COLOR PHOTOGRAPH BY VALENTINO SARRA

## LIKE FATHER LIKE SON

PIERRE MARCHAND was as meticulously careful in the instruction of his young son as he was in the practice of his art. Pierre was a binder of fine books, as had been his father and grandfather before him. It was quite in order then, he reasoned, that his son should carry on the family tradition. To Pierre Marchand, one profession, or one business, or one trade was enough for any one family.

Choice of a career has never been much of a problem for members of the Lilly family. While it is hardly likely that Colonel Eli Lilly so intended, their future was cast when, nearly seventy years ago, he opened the first Lilly Laboratory. Colonel Lilly builded well. The sound business and ethical principles which he cherished have been engendered into the Lilly organization, which has remained a leader in scientific progress into the fourth generation.

Lilly




CAPSULAE *Vitae*

To THOUSANDS of persons suffering with pernicious anemia, Pulvules 'Extralin' (Liver-Stomach Concentrate, Lilly) are indeed the "capsules of life." Accurately standardized on actual patients in relapse, 12 Pulvules 'Extralin' daily provide an average adequate maintenance dose. 'Extralin' solves the problem for the patient who is allergic to parenteral liver, and provides a convenient, stable, and pleasant-to-take product for the individual who is not able to arrange for regular parenteral therapy. Available through leading prescription stores everywhere.

ELI LILLY AND COMPANY · INDIANAPOLIS 6, INDIANA, U. S. A.

Wyeth

Longer and busier work days, with a shortage of materials and skilled help—these and other worries that increase the tension of the war years play havoc with those health habits so essential to well-being.

Petrogalar gently, persistently, *safely* helps to establish "habit time" for bowel movement. An aqueous suspension of pure mineral oil each 100 cc. of which contains 65 cc. pure mineral oil suspended in an aqueous jelly, Petrogalar is evenly disseminated throughout the bowel, effectively penetrating and softening hard, dry feces, resulting in comfortable elimination with no straining and no discomfort.

Five types of Petrogalar provide convenient variability for individual needs. Constant uniformity assures palatability and normal fecal consistency.

Petrogalar Laboratories, Inc., Division
WYETH INCORPORATED, PHILADELPHIA 3, PA.

# Petrogalar

REG. U. S. PAT. OFF.

*helps establish "Habit Time"*




SUPPLIED IN 8 AND 16-FLUIDOUNCE BOTTLES

# *Dietary Protein after Surgery and Other Trauma*

apparently must be maintained at a level above normal in order to assure proper wound healing* and at least average resistance against infection.** The feeding of meat, therefore, in adequate amounts, as soon as it can be instituted, appears doubly advantageous: the protein content of meat is high and of highest biologic value; the human digestive tract appears well adapted for handling meat protein.**

*" . . . in a variety of medical and surgical conditions there may occur a considerable depletion of body protein owing to a combination of factors, of which the two most important are a generally diminished protein intake and an enhanced protein catabolism. This situation inhibits wound healing, renders the liver more liable to toxic damage, impedes the regeneration of hemoglobin, prevents the resumption of normal gastrointestinal activity and delays the full return of muscular strength. It is obvious that to meet the situation an adequate supply of proteins and calories must be made available to the body. . . . This implies at least 150 Gm. of protein and 3500 calories, with as much as 500 Gm. of protein daily when trauma has been severe, as in serious burns." (HOFF, H. E.: Physiology, New England J. of Med. 231:492 [Oct. 5] 1944.)

**"Cannon . . . cites the evidence which indicates that diminished protein intake lowers resistance to infectious disease, and corroborates it by his own experiments . . . it seems probable that the small intestine is better adapted for handling protein (especially meat protein) than for other types of food. . . . it is especially well supplied with enzymes which attack protein, and the digestion of meat has been shown to be more complete than that of foods of vegetable origins." (CRANDALL, L. A., Jr.: The Clinical Significance of the Plasma Proteins, Memphis M.J. XIX:147 [Oct.] 1944.)

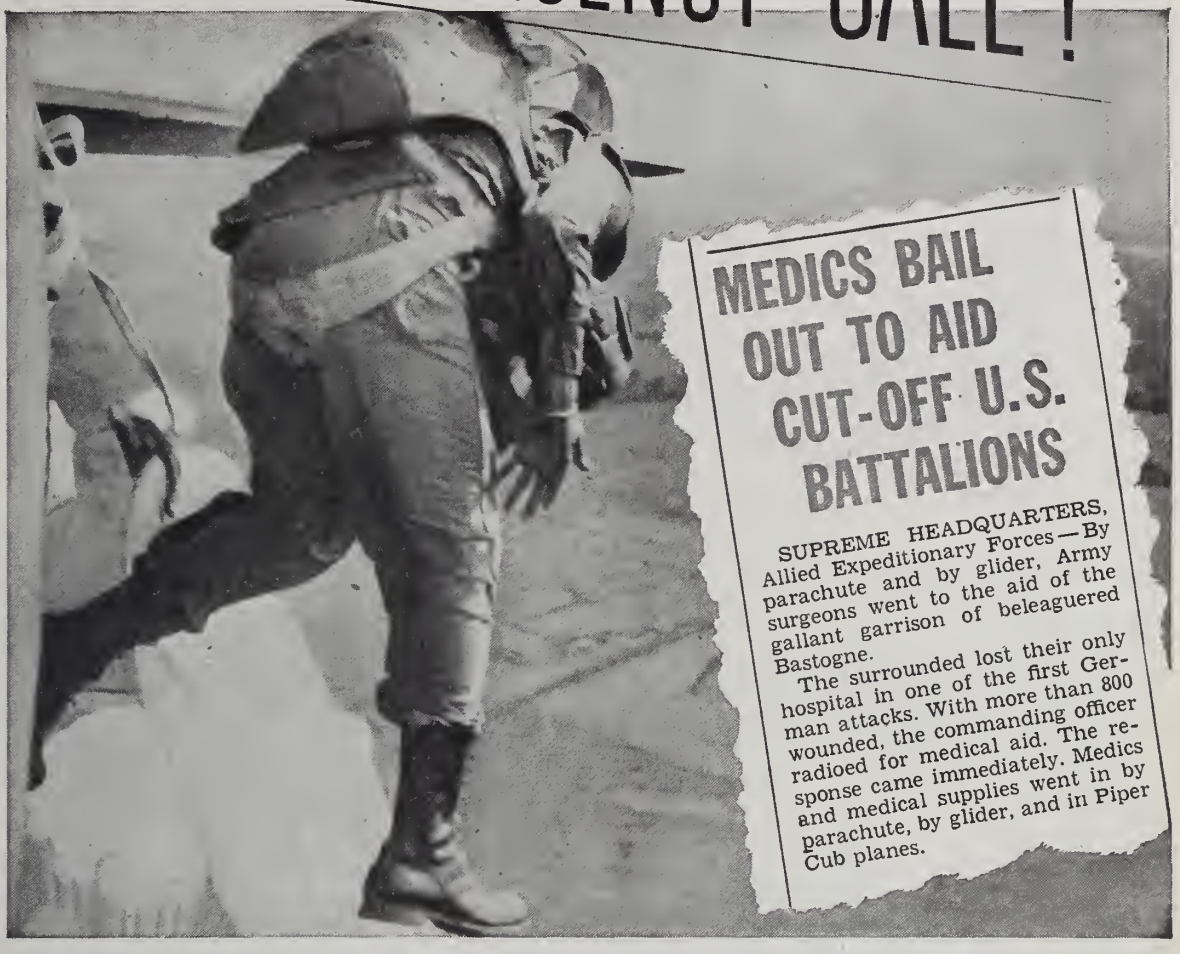
The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

ACCEPTED AMERICAN MEDICAL ASSN. Council on Foods and Nutrition

**AMERICAN MEAT INSTITUTE**

MAIN OFFICE, CHICAGO . . . MEMBERS THROUGHOUT THE UNITED STATES

# EMERGENCY CALL!



## MEDICS BAIL OUT TO AID CUT-OFF U.S. BATTALIONS

SUPREME HEADQUARTERS, Allied Expeditionary Forces—By parachute and by glider, Army surgeons went to the aid of the gallant garrison of beleaguered Bastogne.

The surrounded lost their only hospital in one of the first German attacks. With more than 800 wounded, the commanding officer radioed for medical aid. The response came immediately. Medics and medical supplies went in by parachute, by glider, and in Piper Cub planes.

FROM Bastogne to Leyte, the story is being repeated over and over again—of Army doctors, braving the battle hazards of the front line, risking *their* lives to *save* lives.

Emergency call? *Every* call is an emergency call to these *heroes in white.* And with the Army doctor, as with the fighting men they care for, rest is often limited to a few moments of relaxation and a good cigarette. A Camel cigarette, more than likely, for Camels are the favorite with men in all the services, according to actual sales records.

BUY WAR BONDS STAMPS

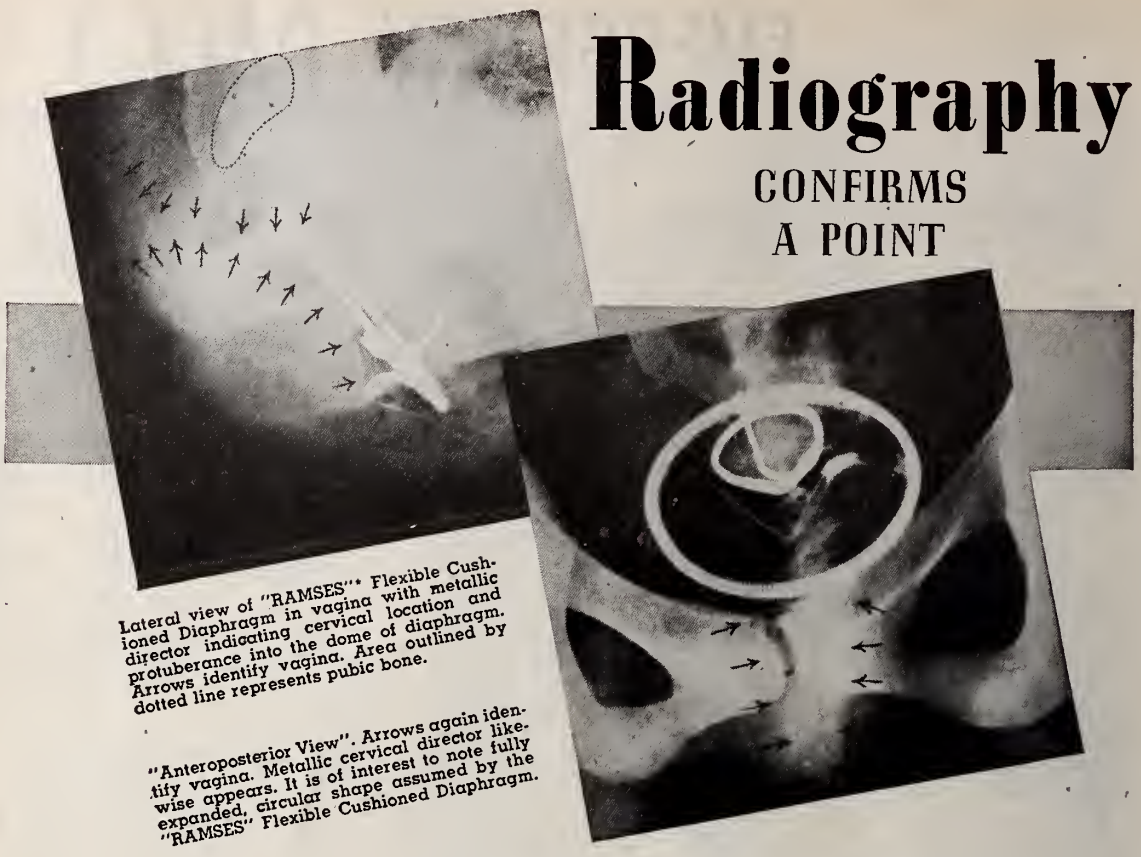



# CAMELS

**COSTLIER TOBACCOS**

R. J. Reynolds Tobacco Co., Winston-Salem, N. C.

# Radiography
## CONFIRMS A POINT



Lateral view of "RAMSES"* Flexible Cushioned Diaphragm in vagina with metallic director indicating cervical location and protuberance into the dome of diaphragm. Arrows identify vagina. Area outlined by dotted line represents pubic bone.

"Anteroposterior View". Arrows again identify vagina. Metallic cervical director likewise appears. It is of interest to note fully expanded, circular shape assumed by the "RAMSES" Flexible Cushioned Diaphragm.

Radiographs of the "RAMSES" Flexible Cushioned Diaphragm in position in the vaginal tract show that the proper placement of a diaphragm of the correct size supplies an effective barrier against sperm movement into the cervical canal.

The broad unindented surface of the patented cushioned rim of the "RAMSES" Diaphragm provides a buffer against discomfort from spring pressure on the vaginal walls.

"RAMSES" Flexible Cushioned Diaphragms are manufactured in gradations of five millimeters in sizes from 50 to 95 millimeters inclusive – they are available on the prescription or order of physicians through recognized pharmacies.

Complete literature on "RAMSES" Diaphragms and instructions for proper fitting will be sent to physicians on request.

*The word "RAMSES" is the registered trade mark of Julius Schmid, Inc.

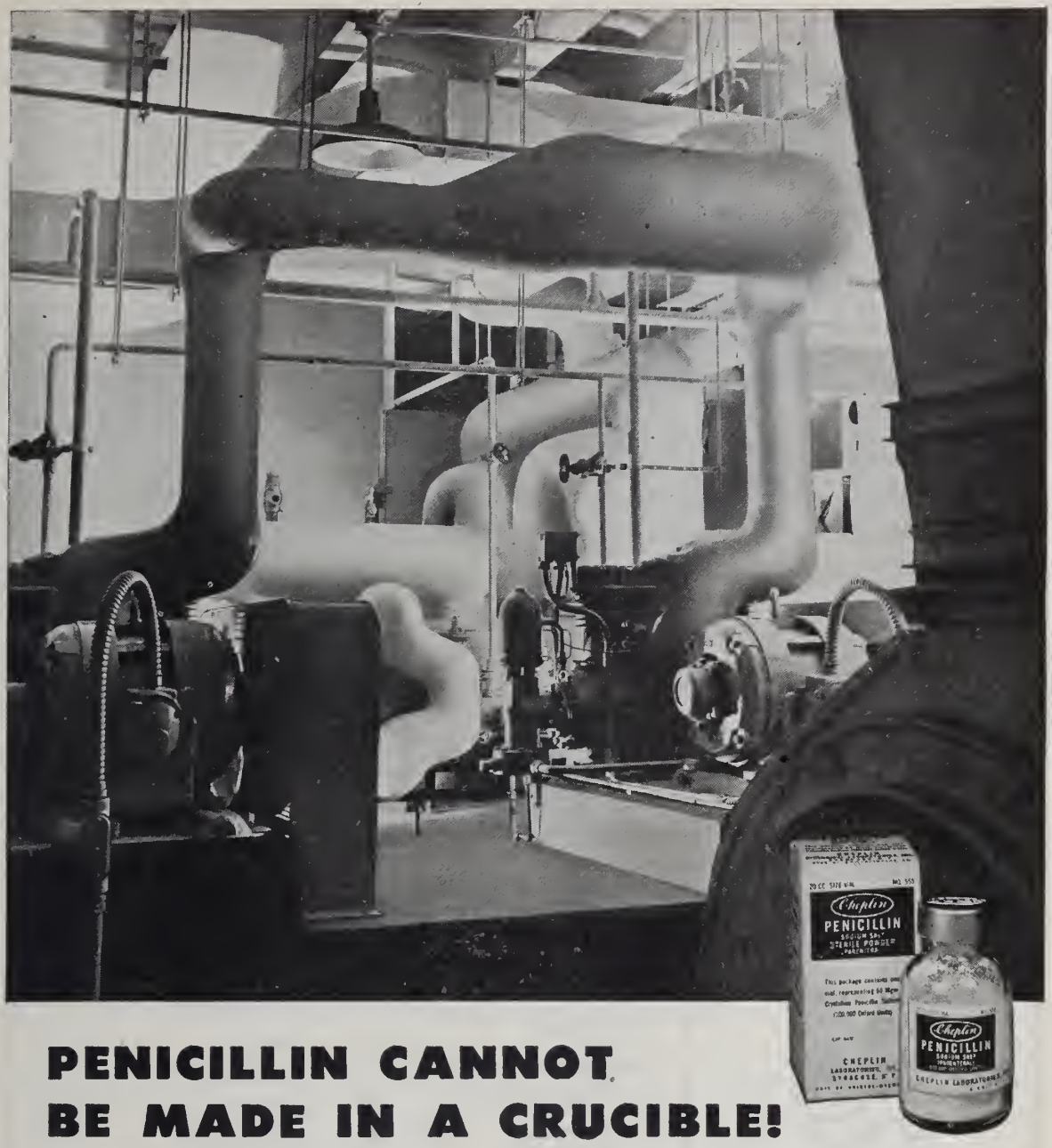
A MARK OF Ramses DEPENDABILITY REG. U.S. PAT. OFF.

Gynecological Division

**JULIUS SCHMID, INC.**

*Established* 1883

423 West 55 St. New York 19, N.Y.




# PENICILLIN CANNOT BE MADE IN A CRUCIBLE!

Bring back Paracelsus and his crucibles today...show him the clinical picture of Penicillin...take him on a trip through a great Penicillin plant like that of Cheplin Laboratories. What would he think? Your guess is as good as ours!

Just as strides in clinical medicine have been unmeasurable since Paracelsus' time, so too have been the strides in mass-manufacture and plant-investment. In the Cheplin plant at Syracuse, for instance, there are alone thirty miles of pipe needed to make this new "wonder-drug."

Who can state Medicine and the Pharmaceutical Manufacturer aren't working together for a better post-war world? And Cheplin is doing its bit!

**CHEPLIN**
**LABORATORIES INC.**
(UNIT OF BRISTOL-MYERS COMPANY)

**SYRACUSE • NEW YORK**

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1. The EYE PHYSICIAN

If glasses are needed, he writes a prescription for the
+ corrective or relieving effect that is required.

1. The GUILD OPTICIAN

The expert fitting such as is available at all times at any Guild Optician's.

= √ √ Double check for accuracy.

## Guild of Prescription Opticians of New Jersey, Inc.

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# WHEN NUTRITION MUST BE MAINTAINED

Few are the diseases in which maintenance of the nutritional state is less important than specific therapy. For unless the metabolic demands of the morbid organism are adequately satisfied, maximal response to drug administration hardly can be expected.

In a host of febrile, infectious, and neoplastic diseases Ovaltine can be of considerable benefit in supplying the extra nutrients required during periods of greater need. This nutritious food drink, made with milk, supplies the dietary elements required: adequate protein, readily assimilated carbohydrate, B complex and other vitamins, as well as important minerals. Ovaltine leaves the stomach rapidly because of its low curd tension, hence may be taken as frequently as deemed necessary. And its delicious taste encourages adequate consumption, an important factor in combating the anorexia of many diseases.

**THE WANDER COMPANY, 360 N. MICHIGAN AVE., CHICAGO 1, ILL.**



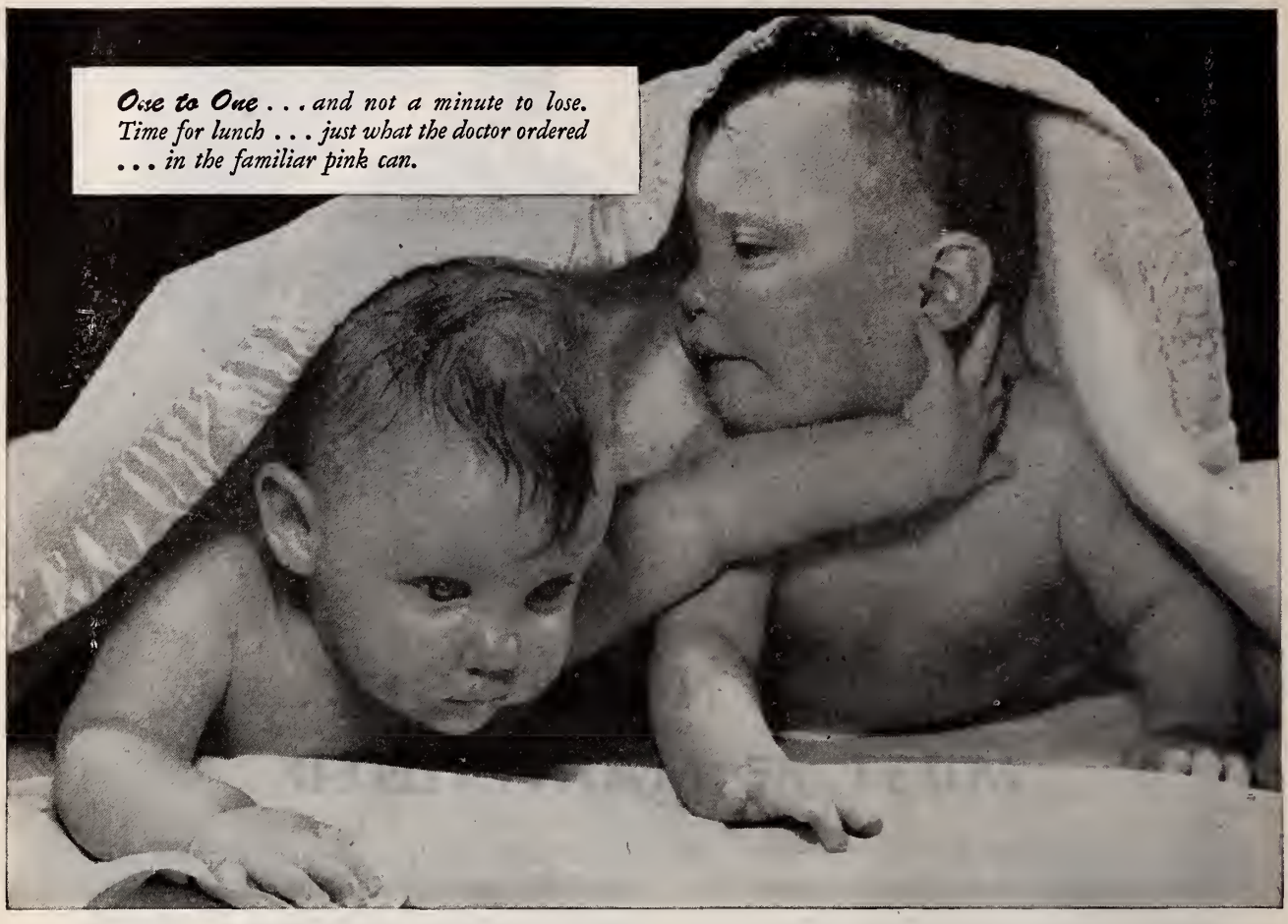

*Ovaltine*

Three daily servings of Ovaltine, each made of ½ oz. Ovaltine and 8 oz. of whole milk,* provide:

| | | | |
|---|---|---|---|
| PROTEIN | 31.2 Gm. | VITAMIN A | 2953 I.U. |
| CARBOHYDRATE | 62.43 Gm. | VITAMIN D | 480 I.U. |
| FAT | 29.34 Gm. | THIAMINE | 1.296 mg. |
| CALCIUM | 1 104 Gm. | RIBOFLAVIN | 1.278 mg. |
| PHOSPHORUS | .903 Gm. | NIACIN | 7.0 mg. |
| IRON | 11.94 mg. | COPPER | .5 mg. |

*Based on average reported values for milk.

Wyeth




# *One to One . . .*

is the S.M.A. rule: one measure* of S.M.A. Powder to one ounce of warm (previously boiled) water, whatever the quantity desired. It is easy to prepare S.M.A. and it is easy for doctors to tell mothers how to do so.

Because S.M.A. is so closely akin to breast milk babies relish it . . . digest it easily . . . thrive on it. Like breast milk the S.M.A. formula remains constant. Only the quantity need ever be changed. S.M.A. babies are such comfortable babies . . . doctors as well as mothers are grateful for S.M.A.

IT'S EASY TO MIX . . .




S.M.A. is derived from tuberculin-tested cow's milk in which part of the fat is replaced by animal and vegetable fats including biologically assayed cod liver oil; with the addition of milk sugar, vitamins and minerals; altogether forming an antirachitic food. When diluted according to directions, it is *essentially the same as human milk* in percentages of protein, fat, carbohydrates and ash, in chemical constants of the fat and in physical properties.

**One S.M.A. measuring cup enclosed in each 16 oz. can of S.M.A. Powder.*

**S. M. A. INFANT FOODS ARE COUNCIL ACCEPTED**

Wyeth

S. M. A. DIVISION • WYETH INCORPORATED • PHILADELPHIA 3, PA.



*For symptoms caused or accompanied by gastric hyperacidity*

Creamalin promptly reduces stomach hyperacidity by adsorption. The effect is persistent. It does not provoke a secondary rise in hydrochloric acid, such as is common after alkalies, nor does it disturb the acid-base balance of blood plasma. . . . Relief is promptly secured and maintained with safety. Hence the very extensive application of this highly useful agent in the management of peptic ulcer and symptoms caused by gastric hyperacidity.

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Supplied in

8 oz., 12 oz. and 1 pint bottles.

# CREAMALIN

Reg. U. S. Pat. Off.

*Brand* of ALUMINUM HYDROXIDE GEL

**NON-ALKALINE ANTACID THERAPY**

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## WINTHROP CHEMICAL COMPANY, INC.

*Pharmaceuticals of merit for the physician*

NEW YORK 13, N. Y. WINDSOR, ONT.



*. . may I suggest you buy more U. S. War Bonds today?*

*I. W. Harper*




it's always a pleasure

# I. W. HARPER

*since 1872*

the gold medal whiskey

**Distilled in peace time and Bottled in Bond under the supervision of the U. S. Government.**

Kentucky Straight Bourbon Whiskey, Bottled in Bond, 100 Proof, Bernheim Distilling Co., Inc., Louisville, Kentucky.

*Indicated therapy in Sequelae of*

*Epidemic Encephalitis*

# Pills Stramonium (*Davies, Rose*)

**2½ grains**

Physicians in private practice as well as in neurological clinics have widely prescribed these pills since 1929, and their continued interest in and use of them points to the serviceability of this therapy.

Stramonium Pills (*Davies, Rose*) exhibit in each pill 2½ grains of alkaloidally standardized Stramonium (powdered dried leaf and flowering top of Datura Stramonium, U.S.P.), equivalent to 25 minims (1.54 cc.) of Tincture U.S.P.

As a reassurance of the activity of the finished pills, they, too, are alkaloidally assayed, thus establishing as far as possible uniformity and dependability.

*A package for clinical trial and literature mailed free of charge upon request.*



**Davies, Rose & Company, Limited**

Manufacturing Chemists, Boston 18, Massachusetts

St-1

# CAMP Belt for Inguinal Hernia



Belt with pad in place



Camp Spring Pad
*(Patented)*



Belt fitted, adapted to all types of build

IN patients with indirect inguinal hernia of small or moderate size, this belt with pad has proved successful in many instances in holding the hernia within the abdominal cavity. The comfort of a *belt* about the pelvic girdle is greatly appreciated by the patient.

The CAMP adjustable spring pad for use with the belt is equipped with prongs of piano wire. The strong flexible prongs fit firmly in the casings of the belt. Pads are available in varying shapes and depths.

The CAMP adjustment of the belt courses along the groin over the pad, hugging it in and up for the protection of the internal ring.

Surgeons who wish some protection over the area after operation will find this belt of particular advantage because the adjustment allows varying degrees of firmness about the lower abdomen.

S. H. CAMP & COMPANY • JACKSON, MICHIGAN • *World's Largest Manufacturers of Scientific Supports*

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Nubrest

## A Breastform for Amputations

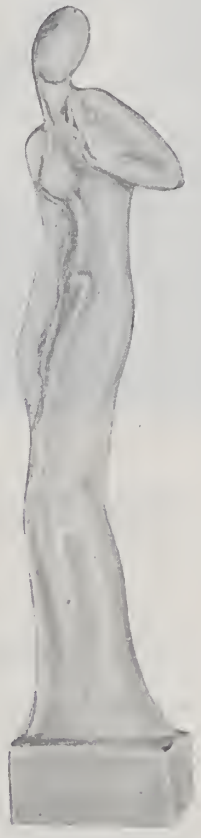
When surgery deprives a woman of the perfection of her breast contour, the practical woman is in quest of restoration of her interrupted breast line.

Nubrest . . . is made of Ventilex, the new air-filtered fabric — soft to the touch — defies detection by contact.

Fits securely and comfortably into a properly fitted brassiere. Can be washed daily in soap suds.

Fitted in all sizes while the patient waits. Made to order, too, if necessary.

Write for our new Reference Book for Physicians and Surgeons. Sixty-four pages of modern surgical and orthopedic appliances often prescribed by the busy practitioner.



ROBERT H. WUENSCH

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Open Mon., Wed.
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## FROM CRUDE DIGITALIS...TO PURE DIGALEN

Painstakingly purified and accurately standardized, Digalen 'Roche' represents "digitalis at its best." Years of clinical experience have confirmed the dependability and efficacy of Digalen in all cardiac disorders responsive to digitalization. Digalen contains all the cardio-active glucosides of *Digitalis purpurea* in highly purified form, free from inert waxes, gums and resins present in the crude drug. In its manufacture no effort is spared, no precaution neglected, no safeguard overlooked to assure the unvarying potency, impeccable purity and dependable standardization of Digalen.

HOFFMANN-LA ROCHE, INC., NUTLEY 10, NEW JERSEY

*Digalen* 'ROCHE'

Wyeth

REG. U. S. PAT. OFF.

# *Special Foods* FOR INFANT NUTRITION




SMACO

## PROTEIN S.M.A.*
**(ACIDULATED)**

***An acidulated, easily digested high protein formula for all infants requiring a high protein intake***

Protein S.M.A. Acidulated is a valuable aid in the management of premature and undernourished newborn infants, in cases of marasmus and malnutrition, in cases of diarrhea . . . This food has an easily digested curd and a liberal vitamin content . . . To increase the caloric value add Alerdex as the carbohydrate . . . As the infant recovers and weight reaches normal, it is well to begin feeding standard S.M.A.

***Powder: 8-ounce tins***

## HYPO-ALLERGIC*
**WHOLE MILK**

***For infants and children showing an allergenic reaction to proteins in cow's milk***

Hypo-Allergic Milk is cow's milk rendered less allergenic by means of prolonged thermal processing which changes the character of the protein molecule . . . When liquefied it may take the place of whole cow's milk in any infant formula; in the same proportions, ounce for ounce . . . It may be used as a beverage and to replace milk in cooking for allergic adults, as well as children.

***Powder: 1-pound tins***
***Liquid: 15½-ounce tins***

## ALERDEX*
**Protein-Free Maltose and Dextrins**

***A carbohydrate for routine use in all milk formulae***

Alerdex, a protein-free carbohydrate, is especially valuable in the preparation of formulae for the protein-sensitive infant . . . It is the ideal carbohydrate for the physician's favorite formula . . . Alerdex is prepared from non-cereal starch by a process which tends to hydrolyze completely all traces of protein . . . It is a valuable adjunct to special diets with Hypo-Allergic Milk and Protein S.M.A. Acidulated.

Calories: 27½ per tablespoonful.

***Powder: 16-ounce tins***

*REG. U. S. PAT. OFF.

ACCEPTED AMERICAN MEDICAL ASSN. Council on Foods and Nutrition

**AT PHARMACIES ONLY**

**THESE ARE SMACO PRODUCTS FROM THE S.M.A. DIVISION**

**WYETH INCORPORATED • PHILADELPHIA 3 • PA.**

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*Afforded Members of*

## THE MEDICAL SOCIETY OF NEW JERSEY

*Since 1921*

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Authorized broker to negotiate professional liability contracts for The Medical Society of New Jersey

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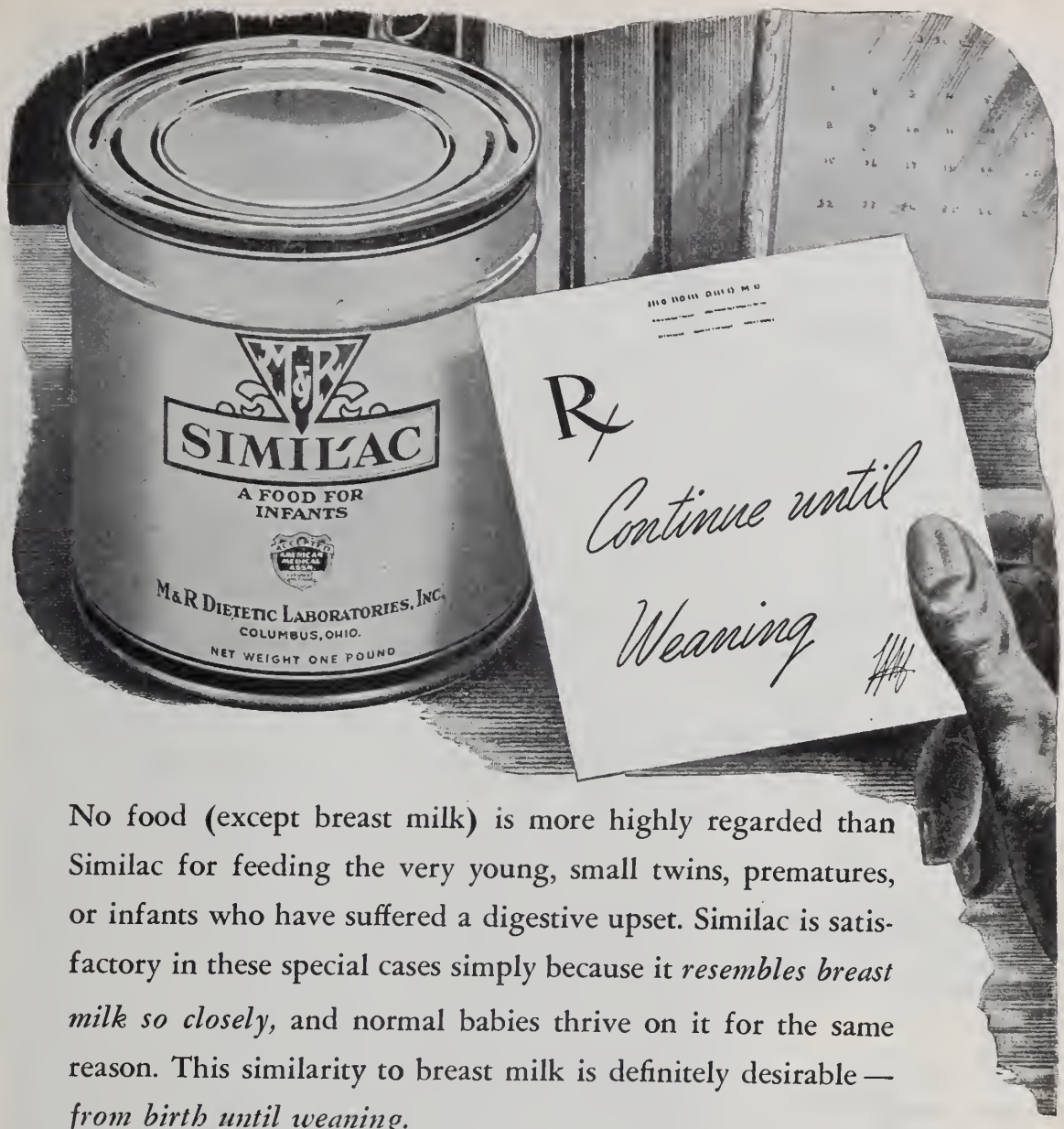
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Kindly send information on limits and costs of Society Professional Policy.

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No food (except breast milk) is more highly regarded than Similac for feeding the very young, small twins, prematures, or infants who have suffered a digestive upset. Similac is satisfactory in these special cases simply because it *resembles breast milk so closely,* and normal babies thrive on it for the same reason. This similarity to breast milk is definitely desirable — *from birth until weaning.*

A powdered modified milk product especially prepared for infant feeding, made from tuberculin tested cow's milk (casein modified) from which part of the butterfat is removed and to which has been added lactose, olive oil, cocoanut oil, corn oil, and fish liver oil concentrate.

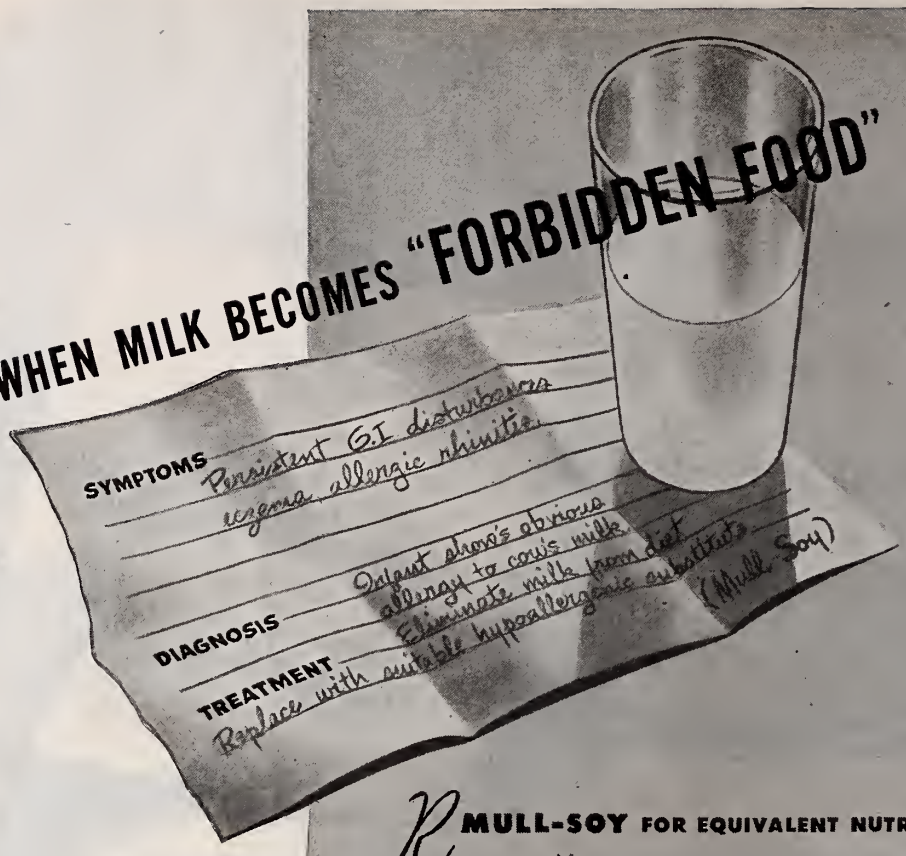
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One level tablespoon of Similac powder added to *two* ounces of water makes *two* fluid ounces of Similac. This is the normal mixture and the caloric value is approximately 20 calories per fluid ounce.

# SIMILAC } SIMILAR TO BREAST MILK

**M & R DIETETIC LABORATORIES, INC. • COLUMBUS 16, OHIO**

# WHEN MILK BECOMES "FORBIDDEN FOOD"




## ℞ MULL-SOY FOR EQUIVALENT NUTRITION

While the manifestations of milk allergy or intolerance are most often seen in infants, they may be present at any age. And, when successful treatment demands complete elimination of milk from the diet, replacement by food approximately equivalent in nutritional elements becomes imperative.

MULL-SOY is an effective hypoallergenic substitute for cow's milk . . . a concentrated, emulsified liquid soy bean food which closely approximates cow's milk in protein, fat, carbohydrate and mineral content. It is palatable, well tolerated, easy to digest, and easy to prepare. Infants particularly relish MULL-SOY . . . and thrive on it!

Copies of "TASTY RECIPES FOR MULL-SOY IN MILK-FREE DIETS" are available for distribution to milk-allergic patients. Write

BORDEN PRESCRIPTION PRODUCTS DIV., 350 MADISON AVE., NEW YORK

## COMPARATIVE COMPOSITION

| 1 Part Mull-Soy 1 Part Water | | Average Whole Cow's Milk |
|---|---|---|
| 3.1% | Protein | 3.3% |
| 4.0% | Fat | 3.8% |
| 4.5% | Carbohydrate | 4.9% |
| 1.0% | Total Minerals | 0.7% |
| 87.2% | Water | 87.3% |

Each provides 20 calories per fluid ounce




# MULL-SOY

**Hypoallergenic Soy Bean Food**

MULL-SOY is a liquid emulsified food, prepared from water, soy bean flour, soy bean oil, dextrose, sucrose, calcium phosphate, calcium carbonate, salt and soy bean lecithin, homogenized and sterilized. Available in 15½ fl. oz. cans at all drug stores.

ACCEPTED AMERICAN MEDICAL ASSN. Council on Foods



Original illustration from Principles and Practice of Obstetric Medicine, by D.D. Davis, M.D., London, 1836.

# TO EASE THE BURDEN

It is the province of the physician to assist the patient through difficult periods of life, whether they be the result of structural or functional defects, and to contend with those conditions which oppose natural, healthy functioning of the human body. Schering is privileged to share this province by developing and providing new and rational therapeutic agents for the physician which enable him effectively to combat many of the problems of adolescence, pregnancy, and the menopause.

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# PENICILLIN SCHENLEY

*Product of a common mold...but most uncommon care*

The mold which produces penicillin is a mold of a fairly *common* variety, occurring freely in nature. But the production of penicillin for the medical profession depends upon precautions to insure sterility which are *most uncommon.*

One of the most important requirements of the finished penicillin is freedom from pyrogens. Each manufactured lot of PENICILLIN Schenley is tested (as illustrated above) to insure utmost pyrogen-freedom. Such measures of uncommon care will continue to assure the greatest degree of productivity . . . the highest degree of pyrogen-freedom . . . for PENICILLIN Schenley.




SCHENLEY LABORATORIES, INC.

*Producers of* PENICILLIN SCHENLEY • Executive Offices: 350 Fifth Avenue, N. Y. C.



## "All the tools I'll ever want," says Handy Andy

and with this simple kit Andy's a "wander" on a lot of odd jobs.

But you're not asking Handy Andy to tune up your car engine; nor to repair your wotch.

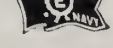
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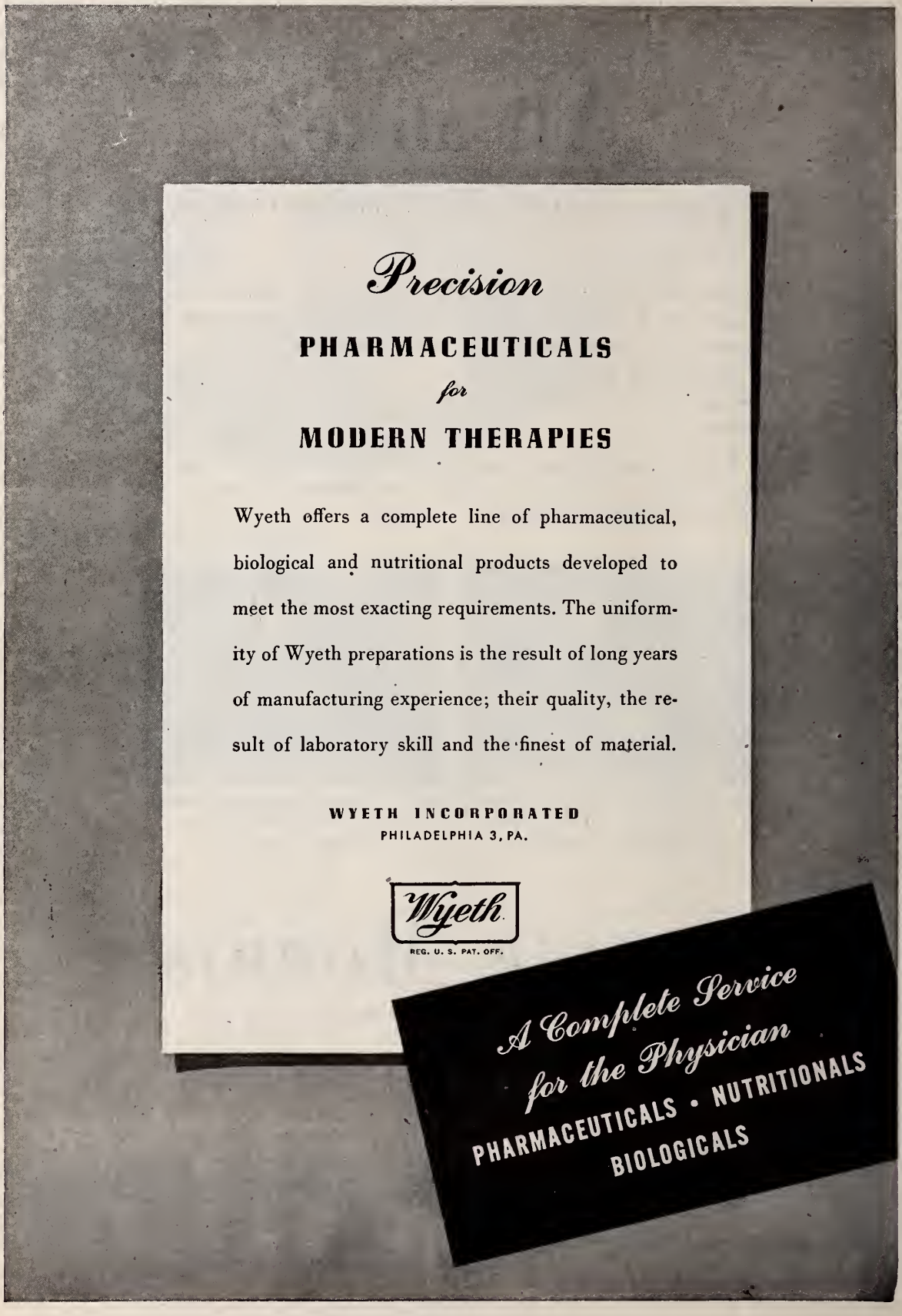
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*Proc. Soc. Exp. Bio. and Med., 1934, 32, 241-245.*
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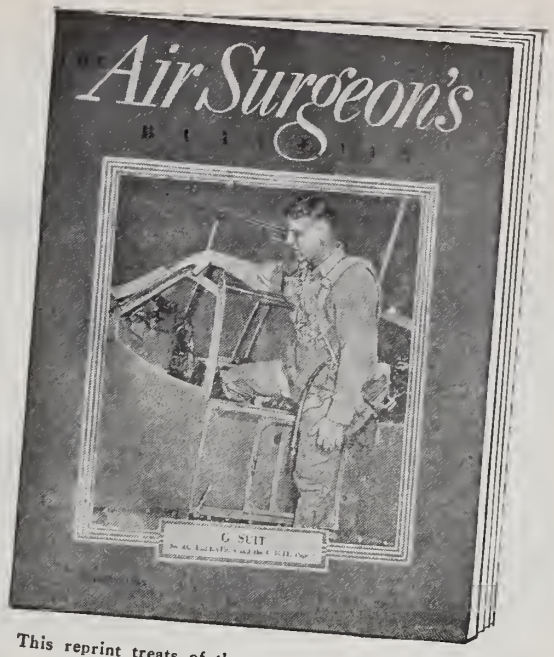

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1. Coburn, A. F.: Salicylate Therapy in Rheumatic Fever, Bull. Johns Hopkins Hosp. *73*: 435-464 (Dec.) 1943.
2. Smull, K., Wégria, R., and Leland, J.: The Effect of Sodium Bicarbonate on the Serum Salicylate Level, J.A.M.A. *125*: 1173 (Aug. 26) 1944.
3. New and Nonofficial Remedies, 1943, p. 57.

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1. Am. J. Dis. Child. 66:1 (July) 1943.

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THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

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Committee on Publication




Henry C. Barkhorn, M.D., Chairman

Henry A. Davidson, M.D., Editor
In Active Service A. U. S.

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Vol. 42, No. 3 March, 1945 Subscriptions, $3.00 per Year
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# EDITORIALS

## 1945 ANNUAL MEETING CANCELLED

Plans and arrangements for the 1945 Annual Meeting in Atlantic City are being cancelled in accordance with the decision of the War Committee on Conventions which reviewed our application for permit to hold the meeting—"It is the consensus of the Committee that this meeting should be deferred until such time as the necessity for the present restrictions ceases to exist. Permit is therefore denied."

Arrangements for a substitute business meeting are under way and the time, place and program will be announced as soon as completed.

We appreciate the fine coöperation and splendid programs prepared by the members of the Annual Meeting Committee, Scientific Program Committee, and the Section Officers, and regret the necessity of cancellation.

Joseph F. Londrigan, M.D.,
*President.*

## PUBLIC RELATIONS TOWARD NATIONAL SICKNESS INSURANCE

More and more people are becoming interested in, and asking more questions about, the medical care distribution problem. It is essential that the individual physician be able to answer their questions intelligently, constructively and without arousing a spirit of antagonism against the opinions of the profession. For this reason *The Journal* will from time to time publish an editorial indicating what it believes to be the proper approach to be assumed by the individual physician.

In discussing the problem with patients

or friends speak as a physician, as a member of The Medical Society of New Jersey, and emphasize the fact that you are expressing the opinion of the majority of physicians.

We all, including the medical profession and labor, want adequate medical care of high standard available to all people. The controversial part of the problem relates to how this is going to be accomplished in New Jersey.

We may first set aside the problem of the indigent and medically indigent as a joint responsibility of government and the medical profession. If medical care for these groups is to be paid for, the only source of payment is by the use of tax money. Its accomplishments will require education of our communities and legislators concerning their responsibilities for these groups. This is exemplified by the program of the City of Newark which provides for the payment not only for medical care rendered the indigent confined to their homes because of illness, but also for similar care of those families who in the opinion of the Department of Health, are medically indigent.

Our most important, and most difficult problem involves that large group of employed, self-supporting, self-respecting persons whose income is modest and not sufficient to meet the costs of serious or catastrophic illnesses without financial assistance.

Among those seeking a solution is a group composed of self styled expert planners, political idealists, advanced thinkers and do-gooders who seldom do any good; they believe they can accomplish their objective by compulsory taxation.

We believe a proper solution *cannot* be based upon compulsion, or upon any program which simply raises money to buy medical care.

In many respects a parallel is found in the prohibition law. That law attempted to control the distribution of liquor and overcome the dangers of the excessive use of alcohol. The result was just the opposite of what the law intended. More people drank liquor. They drank liquor of an inferior quality which did incalculable harm to the health and morals of our people. Some social problems cannot be solved by compulsion. You cannot, in a democracy, enforce such laws. Medical care distribution, enforced by law, might result in more medical care being distributed, but it would be an inferior type of medical care and result in deterioration of the health of the nation and of the individual.

The proponents of compulsion would lead our people to believe that under such a program we would each become an Adonis, an Apollo, a Venus, a Sampson or a Sandow. This statement is a sarcastic exaggeration, but it brings out one of the points we wish to make.

If we are to improve the health of the nation and of the individual, our program must be on a scientific, evolutionary basis. It is something which cannot be accomplished merely by money or law. For example: by evolutionary, scientific advancement such scourges as diphtheria, smallpox, typhoid and summer diarrheas of children have been eliminated. But until a cure or control was discovered, no amount of money could have produced a cure or control of these diseases, and when this was found the cost became nominal. The same may be said about pneumonia and infections since the discovery of the sulfa drugs.

Money raised by compulsion to pay for medical care cannot buy a cure for leukemia or a solution for the cancer problem. It cannot buy a cure for the degenerative diseases of the heart, arterial system or kidneys, which constitute the most common causes of death. We will still have the same number of mental defectives, insane and psycho-neurotics. The common cold, arthritis and rheumatism will still be the most common causes

of days lost from work, until scientific medicine finds a solution.

Do not expect too much from the medical profession. Our progress must await scientific advancement, and we have many unsolved problems. Do not expect the medical profession to accomplish what should be accomplished by education, by better food, clothing, housing and sanitary surroundings.

Money can be used to promote scientific advancement, to improve medical education, to promote better public health measures and to erect necessary medical facilities. By using money for these purposes we will be nourishing the root of the problem, which will then flower into better medical care and better health, but you cannot produce the flower without nourishing the root.

Medical care, in so far as it has advanced on this evolutionary and scientific basis, could be made more available to all people if the economic barrier which sometimes exists between the patient and physician could be broken down. It is purely an economic problem, and in its solution the scientific and evolutionary basis of progress in medicine must not be jeopardized. Perhaps it can be accomplished on an insurance basis, rather than by compulsory taxation. If on an insurance basis we believe it should be on a voluntary basis, thus leaving to the individual his right to solve his own problem as he sees fit. We believe the program should also be evolved in accordance with local needs, rather than through federal control. Our reasons for these principles may be expressed as follows:

Since the day the first Pilgrim set foot on Plymouth Rock this country has been a land of opportunity and personal freedom, a refuge for oppressed people who want to determine their own destinies, assume responsibility for their own welfare and conduct their private lives without interference by a dominating government. We have done pretty well in this country by maintaining these principles and traditions. They must be preserved, and we must never sacrifice our personal freedom or the freedom of any group to promote our personal security.

Our government, therefore, is organized as a democracy, with governing bodies elected by the people at federal, state and community levels. This was done in order that we might solve our problems at a local level; so that our various social and economic groups might solve their own problems by reconciliation of opinions among themselves or with local government. Only when problems cannot be solved on such a basis is it justifiable or safe to refer them to higher echelons of government. Only by referring problems to higher echelons of government do we endanger our personal freedoms by developing a bureaucratic, centralized and dominating type of government. If we continue to refer our problems to the federal government we cannot avoid the development of such a form of government. Thus we may unwittingly lead ourselves into a situation under which government controls the individual, instead of our present system under which the individuals control the government.

We must not promote, or allow the development of such a system of government in this country. The medical care distribution problem must not be referred to federal government. It must be solved on a state basis and in accordance with the needs of each individual state. That is where it belongs.

In accordance with the above principles The Medical Society of New Jersey and its individual members will continue to guide public opinion, and find a solution for this problem which will be to the best interest and welfare of the people of New Jersey.

## NEW JERSEY PHYSICIANS COMMITTEE

As an outgrowth of the endorsement of the National Physicians Committee for the Extension of Medical Service by the State Society in January, representatives of the twenty-one County Medical Societies were invited to attend a dinner meeting at the Essex House in Newark on February 28, 1945, by Mr. Edward F. Stegen, Associate Administrator of the N. P. C. Eleven counties were represented.

Dr. James F. Norton, presiding, introduced Mr. Stegen and Dr. Edward R. Cuniffe, President-Elect of the New York State Medical Society. Mr. Stegen gave a brief resume of the aspects of the work of the Committee, what they are doing, what they stand for and their future program. At present the N. P. C. is engaged in three principal activities: (1) Renewal of the survey of public opinion; (2) public relations and education; and (3) legislation.

Following an informal discussion and question-and-answer period, those present unanimously adopted a motion that the Chair be empowered to select a nominating committee from among the membership of the State, or the group present, for the selection of a permanent Chairman, Secretary and Treasurer, and that the Nominating Committee be empowered to consummate the organization of the State.

President Londrigan emphasized the need for the education of the profession. In answer to this, Mr. Stegen has volunteered his services to speak at District meetings to which will be invited the medical and allied professions, civic and labor groups.

At Dr. Londrigan's invitation all present signified their acceptance of membership on the New Jersey Physicians Committee. Additional members from those counties not represented will be appointed by the Chairman.

The following Officers were appointed by the Nominating Committee:

Chairman—Dr. Joseph F. Londrigan, Hoboken
Secretary—Dr. Chester I. Ulmer, Gibbstown
Treasurer—Dr. William F. Costello, Dover

Joseph F. Londrigan, M.D.

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## COMPULSORY INSURANCE LEGISLATION IN CALIFORNIA AND NEW YORK

Events which may set a precedent for other States are taking place in California, and taking place rapidly.

On January 24, 1945, Assembly Bill No. 800 was introduced in the State Legislature and referred to the Committee on Public Health. Contemporary Bills have been introduced by California Medical Association and by the Council on Industrial Organization. Bill No. 800, if enacted, will establish a compulsory prepaid health service system. It has the approval and sponsorship of Governor Warren. The immediate background is as follows:

The intent of the Governor was first made known to California Medical Association on December 2, 1944. On December 13th the Governor appeared before the Council of the Association and outlined the reasons for his proposals and the content of the proposed Bill. On January 5, 1945, at a special meeting the House of Delegates expressed itself in a series of resolutions to the effect that it could not endorse any system of compulsory health insurance which had thus far come to its attention and expressing a willingness to meet with representatives of government, labor and others for the purpose of arriving at a comprehensive plan to provide adequate medical care for all people in the State. On January 8th in his annual message to the Legislature

the Governor recommended that the Legislature take action during its present session on a program to bring adequate medical care to the people of the State on a prepaid basis. On January 24th the Bill was introduced. They work fast in California.

The Bill provides for organization of the California Health Authority as the administrative agency of the program. The Authority shall consist of eleven members and a manager. In addition to the State Director of Public Health, the Governor shall appoint ten other members of the Authority; three representatives of employers, three of labor which shall include two from organized labor, three holding a license to practice medicine and surgery of which one shall be experienced in hospital management, one licensed dentist.

The Authority shall have power to promulgate or alter rules and regulations necessary to carry out the program, regulate standards of service, fees to physicians, etc. The Bill does not specify the methods of paying physicians or amounts to be paid to hospitals.

Money with which to carry out the program will be raised by taxation of three per cent on all incomes up to the first $4000, one-half to be paid by the employer and one-half by the employee, through pay-roll deduction payable to the State Treasurer who will establish a State Health Fund.

Eligible services are those of the general practitioner, consultant, specialist, hospitalization, laboratory and x-ray, drugs and dental care. Dental care is limited to extractions and treatment of oral infections and fractures.

The writer notes no provision for the indigent or unemployed. The unemployed are covered for only 30 days after cessation of employment or until recovered from disease or injury causing loss of employment. Hospitalization is limited to 21 days per year for any one illness.

Tax collection will start on July 1, 1946, and eligible services will be available on January 1, 1947. These dates may be postponed by order of the Governor if the country is still at war on April 1, 1946.

### New York State

Assembly Bill No. 261 was introduced in the New York Legislature on January 12, 1945, and referred to the Committee on Ways and Means.

The Bill creates a Health Insurance Board in the State Department of Health. Members of the Board shall be the Health Insurance Commissioner, State Commissioner of Health and thirteen members appointed by the Governor with consent of the Senate. Four members shall represent employers, four organized labor, two general practitioners of medicine, one medical specialist, one dentist and one hospital administrator. The Board shall establish administrative standards and make such rules and regulations as required for enforcement of the act.

Physicians may be paid by a salary system, per capita system or fee system. Free choice of physician from among participating physicians is provided.

All persons in the State are eligible. Payment of premiums will be made by an employer contribution of one per cent of pay roll which will be matched by State funds. No deduction will be made from employees' salaries. Persons not employed may make voluntary payments on the same basis. Premiums will be payable on or after January 1, 1945, or when the Act becomes effective.

Benefits will become available eighteen months later. Both cash benefits and medical benefits are provided. Cash benefits shall be in accordance with amounts payable under the State unemployment insurance law during periods of unemployment due to illness for not more than twenty-six weeks per year.

Medical benefits shall be available to employees and their dependents. Medical

benefits shall be general practitioner's care in the office, home, hospital or elsewhere and specialist's care as prescribed by the general practitioner; laboratory services as prescribed, services of nurses outside of hospital and dental care for the relief of pain. Benefits available for not exceeding twenty-six weeks a year for any one illness, but care of a specialist and laboratory benefits shall be limited to twelve weeks. Allowances beyond these time limits are provided by payment of part of the benefit if the formerly employed person shall continue payment of his premiums on a voluntary basis.

No provision was noted for the care of the indigent, the amounts payable to physicians or the amounts payable to hospitals. These will apparently be determined by the Health Insurance Board.

## PARTICIPATING PHYSICIANS MEDICAL-SURGICAL PLAN OF NEW JERSEY

There are now about 3400 New Jersey physicians who have signed Agreements as Participating Physicians to the Plan.

This message is directed particularly to physicians in Middlesex and Cumberland Counties. These County Societies recently approved Medical-Surgical Plan and the members have responded very well. We do need ten more Participating Physicians in Middlesex County and six more in Cumberland County to reach the required 51 per cent of physicians in each County necessary before applying for a license to operate.

In the month of March the State Society will meet with representatives of industry and labor to discuss the medical care distribution problem. We would like to be able to say at that time that the Plan is available to groups of those Counties.

The following copy of our Agreement with Participating Physicians, if signed and returned to 31 Clinton Street, Newark, New Jersey, will be accepted by the Plan.

### MEDICAL-SURGICAL PLAN OF NEW JERSEY
Newark, New Jersey

### Agreement with Participating Physician

I, THE UNDERSIGNED, a physician holding a full license to practice medicine in the State of New Jersey pursuant to Chapter Nine, Title 45, of the Revised Statutes, in consideration of being accepted as a Participating Physician of Medical-Surgical Plan of New Jersey (herein termed Plan), pursuant to Chapter 48-A, Title 17 of the Revised Statutes, and acts supplementary thereto and amendatory thereof, on the basis herein set forth, do hereby agree with the Plan as follows:

I will perform the medical and surgical services specified in the subscription certificates issued or that may be issued by the Plan, in accordance with accepted practices in the community at the time the services are rendered and at such rates of compensation as shall be determined by the Board of Trustees of the Plan. I will abide by the By-Laws, Rules and Regulations of the Plan applicable to Participating Physicians, copy of which shall at all times be available in the office of the Plan.

Thirty days' written notice of termination of this agreement may be given by me to the Plan at any time, but shall not apply to any subscription certificate in force at the time of such notice until the first date thereafter when eligibility for payment for services under such subscription certificate may properly be terminated by the Plan.

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# ORIGINAL ARTICLES

## THE ROLE OF VITAMINS IN THE PHYSIOLOGY OF VISION *

William H. Hahn, M.D., Newark, N. J.

Ophthalmologists are daily confronted with the problem of ocular diseases in which the etiology is obscure and therapy unsatisfactory. The rapidly advancing knowledge of nutrition indicates that in some of these disorders a deficient diet may be the sole cause or a contributing cause, and that the provision of proper dietary factors, alone or in conjunction with other therapy, facilitates recovery.

It has long been known that people on poor diets suffered ocular disorders. Empiric remedies were discovered for some of these disorders, such as feeding liver to those suffering from night blindness. The discovery and study of vitamins led to the recognition of the fact that they play an essential part in the metabolism of all tissues and that their lack led to an interference of function of these tissues.

Currently, the most striking advances in nutritional knowledge center about the vitamins and it is of interest to review some of their known actions, with particular reference to the physiology of the eye. From the clinical standpoint conditions more subtle in their manifestation than the classical deficiency diseases now appear to be caused by functional disturbances associated with vitamin deficiencies.

For purposes of this paper we will consider only those vitamins which have been demonstrated, both clinically and in the laboratory, to exist in the ocular tissues and to be of specific importance there. These are Vitamins A, B, including thiamin, riboflavin, C, E, P, K. There are many other vitamins, and other nutritional factors which are important.

The principal known physiological actions of vitamins have become part of the definition of vitamins. Vitamins are defined by Rosenberg [1] as "organic compounds, which are required for the normal growth and maintenance of life of animals, including man, who as a rule are unable to synthesize these compounds by anabolic processes that are independent of environment other than air, and which compounds are effective in small amounts, do not furnish energy and are not utilized as building-units for the structure of the organism, but are essential for the transformation of energy and for the regulation of the metabolism of structural units."

The primary physiological action of most vitamins is scarcely known. The observations made in experimental studies are in many cases secondary symptoms and it is very difficult to decide whether the observed actions of the vitamins are of primary or secondary nature. There are some principles which have been established.

The study of vitamins and their action has been both clinical and biochemical. Among the first attempts to understand the action of vitamins was the histological study of tissues from vitamin deficient animals.

The degeneration of myelin sheaths of peripheral nerves in beri-beri, a Vitamin B deficiency disease, described forty years ago, represents a classical observation.

Histological studies in Vitamin A deficiency are more recent than those involving Vitamin B. The characteristic metaplasia which epithelial structures in any part of the body may undergo in this deficiency helped in determining the sphere of action of vitamins. The histological studies of Vitamin C deficiency have revealed a lack of formation of intercellular material. Vitamin A is concerned with the building of the cell nucleus, and Vitamin E with the maturation and differentiation of cells. Much of the knowledge of the action of vitamins has resulted from a study of changes resulting when the organism is deprived of them.

A nutritional inadequacy begins the instant that adequate amounts of an essential nutrient fail to reach the internal environment.[2] This

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results in malnutrition, the successive stages of which are represented by tissue depletion, biochemical lesions, altered function and finally anatomical lesions.

The clinical recognition of these stages of malnutrition as a rule follows the reverse order, i. e., anatomical lesion, altered function, biochemical lesions and tissue replenishment.

In considering the actions of the vitamins revealed by the study of their chemistry it will be helpful to recall some of the principles of general physiology.

The essential reaction in all metabolic processes is a reciprocal process of oxidation and reduction which throughout the body generally is in large part carried on by the respiratory gases, mediated by the blood stream.[3] By oxidation is meant the addition of oxygen or the removal of hydrogen. The end products of digestion, for example glucose, do not readily unite with oxygen at body temperature.

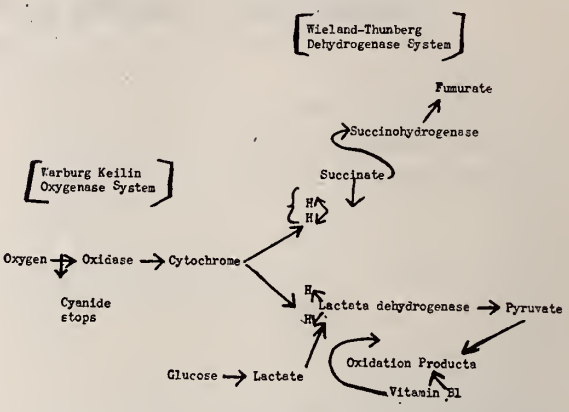
Warburg [4] first showed that something had to happen to molecular, or atmospheric, oxygen before it could be made to take up either hydrogen or electrons. He found that the activation of molecular oxygen could be accomplished by catalytic substances, and that in the tissue cells there are enzymes which he called oxidases, compounds of oxygen and an enzyme, which accomplish this action. Warburg showed that hydrogen transfer is a fundamental operation in the release of energy from body fuel and in this operation dehydrogenases, oxidases, hydrogen acceptors and hydrogen carriers as well as carboxylases, phosphatases, and mytases are involved.

Substances which readily take up hydrogen are called hydrogen acceptors. Enzymes which act as hydrogen acceptors are present in tissues and are called dehydrogenases. One of these is the so-called Warburg's "yellow enzyme", an important factor in which is riboflavin. In these enzyme systems several of the vitamins have been shown to contain chemical groups which can act as hydrogen acceptors.

Important in all tissues, in non-vascularized tissues, such as the cornea or lens, these systems become of especial importance.

It is important to bear in mind the mechanism of action of an enzyme system, for in it the vitamin plays an essential rôle.

A scheme of tissue respiration is pictured:




It may be seen from this that oxygen is picked up from the blood by one enzyme system and passed by means of an intermediary carrier (Keilin's cytochrome) to the specific enzyme systems which activate lactate or other substances in carbohydrate metabolism. Reduction of cytochrome is accomplished through metabolites such as lactic acid. Its oxidation is accomplished in the presence of a catalyst, indophenol oxidase. Hydrogen transport is of considerable importance in oxidative processes.

It appears that Vitamin $B_1$ is effecting sugar metabolism. Without it the process would stop, and we would have, following depletion of the vitamin, a biochemical lesion, with altered function, and finally an anatomical lesion.

It has been demonstrated that Vitamin $B_1$ is especially concerned with carbohydrate metabolism and that it is connected with tissue respiration. It is a catalyst needed for the oxidative removal of one of the lower degradation products of carbohydrate metabolism.

We will now consider in general those vitamins known as A, B, C, E, P and K, in relation to their function in the eye, without considering their subdivision except for some special function.

Vitamin A exists in nature in at least three forms, of which the Carotene found in plants is regarded as a provitamin. Both Vitamin A and Carotene circulate in human blood. It is excreted in the feces.

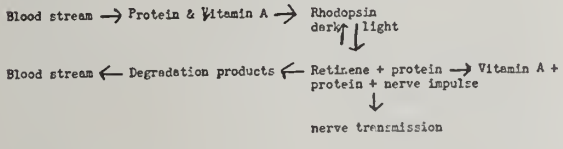
Wald [6,7] found Vitamin A in considerable

concentration in a solution of visual purple extracted from the retina, and in the pigmented choroidal layer of the frog, pig, and cattle.

Yudkin [8] found Vitamin A in large quantities in the retina, chiefly in the rhodopsin. Rhodopsin is a conjugated protein containing a carotenoid pigment as its prosthetic group.

The first significant act in the series of events which we call vision is the absorption of light, particularly light near the middle of the spectrum, and of low intensity, by the rhodopsin. This energy is utilized for the production of chemical change, which results in nerve impulses which are sent to the brain and which we interpret as vision.[9] The absorption of light by the rhodopsin results in the bleaching out of the latter. When rhodopsin is bleached in the light it breaks down into a yellow carotenoid pigment called retinene, and a protein. The yellow color of retinene fades and Vitamin A is produced. While the rhodopsin is bleached, vision is impaired, especially vision in a dim light. In the dark, the rhodopsin is re-synthesized.

The synthesis of rhodopsin is dependent upon the availability of Vitamin A and the metabolic activity of the retina.[10] The accompanying scheme outlines the process.




From this scheme it appears that in the absence of Vitamin A rhodopsin cannot be regenerated. The eye must receive a constant supply of fresh Vitamin A from the blood to supplement that received from the retinene, for some of the Vitamin A is destroyed. The effect of an inadequate supply of Vitamin A is to slow down the rate of regeneration of this pigment and hence to delay the speed with which an eye that has been exposd to light can recover sharpness of vision.

In the mammalian retinae occur other colored substances, some of which are light sensitive. They are cytochromes, riboflavin and its derivatives, thiochrome, hematochromagens, and porphyrins. These substances are all more or less concerned with metabolic processes in which vitamins play a part.

Wald [11] found a photosensitive carotenoid pigment in the cones of the chicken retina as well as three colored filter pigments. Wald [12] stated, "It seems likely now that photoreception, visual or phototropic, throughout all living organisms may be founded chemically upon this single group of substances, carotenoids."

Wolbach and Howe [13] found specific tissue changes following the deprivation of fat soluble Vitamin A in albino rats, and in the human. These changes were found in epithelial tissues, there being a substitution of stratified keratinizing epithelium for normal epithelium in various parts of the respiratory tract, alimentary tract, eyes and para-ocular glands and in the genito-urinary tract. The replacement of epithelium comes from focal proliferation of cells arising from the original epithelium and not by differentiation or change of preëxisting cells. The first morphologic evidence of avitaminosis was found in the cell nucleus. The deficiency results in loss of specific chemical functions of the epithelium, while the power of growth becomes augmented.[14]

In addition to the change in the corneal epithelium, Bessey and Wolbach [19] noted a vascularization of the substance of the cornea and felt that the cornea, deprived of the normally functioning, respiring, epithelium suffered an anoxia. The ingrowth of blood vessels occurred in an effort to provide oxygen from blood to the corneal stroma.

Vitamin B. The term Vitamin B Complex [3] is used to describe a group of water soluble vitamins found necessary for growth in rats. It can be divided into two main fractions, (1) Vitamin $B_1$, heat labile, also called the antineuritic factor, identified chemically as thiamine, and (2) Vitamin $B_2$, heat stable, which includes nicotinic acid and riboflavin, which is part of a complex oxidation system known as "Warburg's yellow enzyme". Thiamin, riboflavin, and nicotinic acid of the Vitamin B Complex are parts of enzyme systems necessary for the fractional dehydrogenating process which results in the utilization of energy from carbo-

hydrate. Riboflavin acts as the coenzyme of the "yellow enzyme", important in cell oxidation.

The known anatomical lesions due to Thiamin deficiency are polyneuropathy, the ophthalmoplegia of Wernicke's syndrome and circulatory disturbances.[32] In these edema, effusion and later sudden circulatory collapse are prominent symptoms.

Before considering the action of Vitamin B it will be helpful to review some of the physiological processes occurring in the cornea, as it appears to be essential to normal metabolic processes in the cornea.

The cornea[15] receives its nourishment by a process of simple diffusion of the intraocular fluid from the periphery, probably directly from the vascular plexus around the limbus, or indirectly from the fluid in the anterior chamber. To compensate for the absence of blood the cornea is possessed of a respiratory mechanism whereby gases are actively transpired through the agency of its epithelium and endothelium. Oxygen and carbonic acid have the ability to pass through the cornea only in one direction, the oxygen passing through the epithelium from the air backwards, towards the anterior chamber. Carbonic acid travels forwards through the cornea to the surrounding atmosphere. Apparently the endothelium requires a very considerable amount of oxygen which it may get from the intraocular fluid directly, but in the absence or insufficiency of this supply it appears to draw on the surrounding atmosphere.

Riboflavin is widely distributed throughout the animal organism. It is present in each cell. The retina of many species of animals contains considerable quantities in the free form. It is present in the normal crystalline lens, and in the cornea.

The water solution is of greenish yellow color and displays an intense yellow-green fluorescence, which vanishes on the addition of acids or alkalies. Decomposition is greatly influenced by light, temperature and ph.

Riboflavin in the free form in the retina plays an important rôle in the visual act. It is converted by light into a photocompound of unknown structure resulting in stimulation of the optic nerve. The primary photocompound is extremely sensitive. In the absence of oxygen it is destroyed, in the presence of oxygen it is reconverted into riboflavin.

In the dim light, light of short wave length is converted by the fluorescent activity of riboflavin, into light of longer yellow-green waves, for which the human eye has a maximum sensitivity.

Heiman[20] regards riboflavin as a conveyor of the physiologic stimulus, a transformer of short light waves into those of maximum intensity and a protector of the cones, against the effect of excessive light.

In its lack we might expect diminished visual acuity, dimness of vision based on the lowered function of transformation and intensification, and photophobia. Riboflavin and carotene have various similar characteristics and either functions to some extent in the absence of the other.

In rats on a riboflavin deficient diet Bessey and Wohlbach found a marked ingrowth of capillaries into the cornea, from the vessels of the limbus. The invading capillaries at first lay just under the corneal epithelium, but soon others grew deep in the tunica propria, until they extended across the cornea nearly to the center. With the administration of riboflavin these blood vessels disappeared. If riboflavin plays an important part in the process by which the cornea receives its oxygen, then without an adequate supply of riboflavin the cornea will suffer an anoxemia. They felt that the rôle of riboflavin as a respiratory carrier suggested that the vascularization was a response to asphyxia. If the respiration of the cornea is dependent upon the ability of the epithelium to absorb and transport oxygen from the atmosphere, the vascularization of the corneal stroma in Vitamin A deficiency as well as in riboflavin deficiency could be the result of an effort to obtain oxygen bearing blood, when oxygen cannot be obtained through the keratinized epithelium, as stated above.

Bessey and Wolbach[19] concluded that vascularization of the cornea of the rat is probably a specific and the most reliable criterion of riboflavin deficiency.

Clinically, Sydenstricker[16] observed a series

of patients suffering a superficial vascularizing keratitis, in whom the corneal lesions disappeared during the administration of riboflavin. The slit-lamp picture of the cornea during the disease corresponded closely with that described by Bessey and Wolbach in rats on a riboflavin deficient diet.

Kruse and Sydenstricker [17] observed two cases of keratitis associated with syphilis, but resistant to anti-syphilitic treatment, when no attempt was made to control diet. Riboflavin therapy appeared to be distinctly beneficial in these cases.

It is likely that Thiamin, as other vitamins, plays an important part in the metabolism of the central nervous system. The symptoms generally ascribed to vitamin $B_1$ deficiency are mostly symptoms of combined deficiencies of several vitamins of the A group, especially $A_2$, Nicotinic Amide, $B_6$, etc.

The essential defects of avitaminoses $B_1$ are a disturbed intermediary metabolism of carbohydrates, and accumulations of intermediary products in toxic amounts; functional and later degenerative changes in the central and peripheral nervous systems; and generalized nutritional changes largely due to interference with gastro-intestinal functions. The abnormality of the carbohydrate metabolism involves improper oxidation and accumulation, particularly in the central nervous system, of lactic and pyruvic acids and of methyl glyoxal. Accumulation of intermediary products of carbohydrate metabolism in nervous tissues is presumably the cause of the neurological manifestations, pain, anaesthesia, paralysis, spasticity, generally termed a polyneuritis.

It was demonstrated by Aring [20] that in persons with pellagra the myelin sheaths were reduced in number. The axis cylinders were involved in the same process, usually in the same severity. What part this plays in the production of polyneuritis is not clear, nor whether it is due solely to vitamin lack. In alcoholics in whom a polyneuritis has developed, including those with visual symptoms, as central scotomata, improvement in symptoms was noted when they were put on a well-balanced high vitamin diet supplemented by yeast or its products.

This led to the conclusion that alcoholic polyneuritis does not result primarily from a direct neurotoxic effect of alcohol, but is probably the result of a dietary deficiency. This coincides with Wechsler's [22] conclusion that avitaminoses played a definite rôle in the production of polyneuritis. Jolliffe [23] showed the important vitamin was Thiamine.

Carroll [24] reported a series of patients suffering a tobacco alcohol amblyopia, with typical centro-caecal scotomata, in whom the patient's usual ration of tobacco and alcohol was continued, but the diet was altered to a well-balanced diet, high in Vitamin B content, supplemented by yeast, wheat germ, and liver extract and cod-liver oil. Eight of the nine patients recovered satisfactory vision.

Carroll called attention to the fact that this type of amblyopia is found in patients with alcoholic polyneuritis, and in those with the alcoholic type of pellagra.

Leinfelder [33] reported the use of Thiamine Hydrochloride in the treatment of Tryparsamide Amblyopia, but without success.

Nicotinic acid is a vasodilator. Its therapeutic use in diseases characterized by attenuation of arteries, as in Retinitis Pigmentosa, has been suggested.

It will be of interest here to review some of the physiology of the crystalline lens.[25] As the crystalline lens is not supplied with blood vessels, but forms an isolated system suspended in the aqueous humor, the lens cannot obtain and utilize oxygen as vascularized tissues do, but depends upon intracellular oxidation systems. The transparency of the lens depends upon its metabolic activity, as energy producing reactions, such as oxygen consumption and glycolysis, are essential for the continuance of the integrity of the lens cells. The most important process appears to be carbohydrate metabolism. This occurs in two stages, first an enzymatic process of glycolysis, whereby glucose is broken down to lactic acid. The second is an aerobic process of inner respiration whereby lactic acid is degraded to carbon dioxide and water. The first reaction is activated by enzymes, in which Riboflavin and Thiamine play important parts. They require substances which act as hydrogen acceptors.

Vitamin C is a strong reducing agent, giving off hydrogen easily, and is probably of fundamental importance in tissue respiration, acting as a hydrogen transport agent.

Vitamin C is present in a relatively high proportion in the lens and in the aqueous humor. In the fully developed lens it is more abundant in the cortex than in the nucleus. Its concentration in the lens falls with age. Its presence in the aqueous, which is normally in much higher concentration than in the blood, is increased by augmenting Vitamin C in the diet. It is decreased in cataract, in aphakia, or in the plasmoid aqueous obtained after paracentesis. Its presence in high concentration in the aqueous seems to indicate a dependence on the presence of an actively functioning lens. The absence of Vitamin C in cataract and aphakia raises the question of the relation of this substance to the formation of cataract.

Metabolically, the most important features in the development of cataract are a diminished metabolism, a decrease in permeability, and a loss of the substances active in oxidation such as cysteine, glutathione and ascorbic acid. Whether the relation is causal or consequential, a cataractous lens is an asphyxiated lens.

Vitamin C is transported by the blood. Its most obvious property is its reversible oxidation and reduction capacity and this property probably plays a large part in the mechanism of its action. One function in the body is that of a hydrogen transporter in cellular respiration. Another is its participation in the formation of colloidal intercellular substances. The clinical symptoms of Vitamin C avitaminosis are summarized under the term scurvy and are mainly characterized by hemorrhagic conditions. The actual place of these is largely influenced by growth and stress.

In the eye Vitamin C is derived from the blood but it is present in the intraocular fluid in a concentration appreciably higher than in the blood.

Friedenwald [26] showed that Vitamin C constitutes an integral part of the secretory mechanism of the aqueous. Vitamin C is stored in the ciliary stroma. Its oxidation by the ciliary epithelium is a step in the process of the formation of aqueous humor.

Secretion of the aqueous humor is accomplished through a process of electro-osmosis, the result of oxidation of the stroma of the ciliary body by the epithelium, due to a difference in the oxidation-reduction potential between them. The oxidation-reduction potential is derived from the action of enzymes and their metabolic substrates.

Friedenwald [27] showed experimentally that in the absence of Vitamin C there was a decrease in the rate of secretion of intraocular fluid long before scurvy develops.

Vitamin E is carried by the blood. The primary physiological action of Vitamin E appears to be concerned with activities of the cell nucleus. It is of especial importance to those tissues in which cellular proliferation and differentiation occur at high speed. This may be of importance in healing processes. Increased permeability of capillaries resulting in hemorrhage and exudation of plasma was found by Dam and Glavind [28] to be an outstanding feature of Vitamin E deficiency in chicks. A sufficient dose of Vitamin E gave complete protection against these exudates.[29]

Vitamin E has been found to prevent excessive proliferation of fibrous tissue in muscles, joints and in the central nervous system.

Stone found a beneficial effect on the rate of absorption of tissue exudates on the administration of Vitamin E in cases of arthritis deformans.[31] On the basis of this he tried administration of Vitamin E in patients suffering from interstitial keratitis of luetic origin and felt that it hastened absorption of corneal exudates and opacities of long standing; that it prevents further organization of scar tissue and that it reduced excessive capillary permeability.[30]

Stone offers for consideration the possibility that syphilis may produce keratitis only when the oxygen supply of the cornea is impaired by riboflavin deficiency.

The natural Vitamins K are fat soluble compounds, though some forms are water soluble. They are obtained from food and also are synthesized by bacteria in the intestinal tract. They are absorbed only in the presence of bile salts. They are found in small amounts in the blood and are necessary for the maintenance

of normal blood coagulation. This may be of importance in some types of retinal hemorrhage. Bleeding not due to Vitamin K deficiency is not influenced by the administration of this vitamin.

Vitamin P is known as the permeability vitamin. Its physiological action is concerned with the maintenance of normal conditions in the walls of small blood vessels, and the absence of this vitamin causes increased capillary fragility and permeability. The clinical symptoms comprise hemorrhagic conditions of the skin which cannot be cured by Vitamin C.

Consideration of the part played by vitamins in the physiological processes of the ocular tissues as outlined above indicates that the presence of these vitamins is essential to the normal functioning of the eye. Without them, or any one of them, it is reasonable to expect that disorders of one kind or another will ensue. There is clinical and laboratory evidence that such disorders do occur, and it is reasonable to assume that when they occur as a result of vitamin deficiency, they will be corrected when the missing vitamin is supplied. There is convincing evidence that this is so.

It is likely that there are other factors involved than simply administration of vitamins by mouth, either in food or in pill form. For example, there is the possibility that absorption of the vitamin will not take place, due, perhaps, to an achlorhydria, or to a lack of bile. The complexity of the chemical action in which the vitamins play their part requires that many other factors beside the presence of the vitamins, the ph for example, may be essential for proper metabolism. This is so in healthy tissue. In the presence of disease, such as syphilis, tuberculosis, focal infection, some of these factors are altered, or removed, or new ones may be introduced. In this way, characteristic lesions such as are seen in the interstitial keratitis of syphilis may be induced, or altered, as suggested by Stone.

There is evidence to indicate that vitamin deficiency plays a part in cataract formation. Present day studies have opened up new fields for further study of this perplexing problem. To date there are no published studies correlating Friedenwald's work on Vitamin C in the secretion of intraocular fluids with the regulation of intraocular tension.

Vitamins found in ocular tissues, and with whose function they are concerned, may be listed as follows:

Vitamin A: Cornea; maintenance of intact epithelium, necessary for the normal respiration of the cornea.

Retina; essential for the regeneration of visual purple when bleached by light, thus permitting vision in a dim light.

Vitamin $B_1$ (Thiamin): Nerve tissue; metabolism of nerve cells, hence the reception and conduction of the visual stimulus.

Vitamin $B_2$ (Riboflavin): Cornea; essential to the respiratory mechanism of the corneal stroma.

Retina; mechanism of light perception, and conversion to visual stimulus.

Vitamin C: Essential to the secretion of intraocular fluid by the ciliary body.

Essential to metabolism and respiration of the crystalline lens.

Vitamin E: Concerned with reparative processes.

Vitamin K: Essential in the process of blood coagulation.

Vitamin P: Concerned with the maintenance of the walls of blood vessels.

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2. Varicocele due to anomalous renal vessel: an instance in a 13 year old boy. J. Urol. 52: 502-504, Dec. '44

EXTON, W. G.; F. SCHATTNER, Ph.D.; S. KORMAN, Ph.D., and A. R. ROSE, Ph.D.—Newark
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# A SIMPLIFIED LOCAL TREATMENT OF SINUSITIS WITH SODIUM SULFATHIAZOLE

## (WITH SPECIAL REFERENCE TO THE ETHMOIDS)

E. Clarence Kern, M.D., F.A.C.S., Montclair, N. J.

No one knows better than the otolaryngologist the difficulty of treating infected ethmoids, which preclude irrigation, and infected frontals and sphenoids in which irrigation is impossible. The ethmoids cannot be reached by irrigation because of their anatomical characteristics. In many cases both frontals and sphenoids also resist this treatment. To reach these sinuses with a curative solution some other technic must be employed.

Having obtained dry ears in a number of cases of acute and chronic middle-ear disease by the local use of sodium sulfathiazole solution or sulfanilamide powder, it occurred to me that these drugs might be useful in treating the sinuses. Since then I have used the five per cent solution of sodium sulfathiazole almost exclusively for the irrigation of the antrum, sphenoid and frontal, and, in the special way which I would like to report, for the treatment of ethmoiditis and other forms of sinusitis, both acute and chronic, in which irrigation is not feasible.

### PRELIMINARY TREATMENT

Since most cases requiring treatment will be found to have obstruction of sinus drainage (the middle turbinate may be in contact with the outer wall or impacted between the outer wall and the septum) the ostia must be opened before treatment is begun. Therefore the middle turbinate is sprayed with 1 per cent Propadrine solution or 1 per cent Tuamine solution and, after a few minutes' wait for shrinkage to occur, a cotton pack, similar to that suggested by Dowling, is inserted.

To prepare the pack a thin oblong of long fibre cotton, about three inches long by one inch wide, with the fibres running the long way, is laid in the palm of the hand. Then a piece of thread, about five inches long, is placed down the middle of the cotton, one end of the thread projecting about two inches. The cotton is then rolled around an applicator which has had its threaded, or triangular, end smoothed by a file. The pack is then dipped in either Propadrine or Tuamine solution.

The cotton cylinder thus prepared should be thin—two or three millimeters in diameter for the average case. This is then tucked under the middle turbinate and allowed to remain about ten minutes. It must be in place—that is, at the upper limit of the recess so that the turbinate is freed from the outer wall and the mucosal lining of the ostia shrunk. The two-inch length of thread hangs from the nares so that the pack can be easily and quickly removed by the nurse. If the first pack does not produce adequate shrinkage a second pack should be inserted.

### TECHNIC

The nurse-assistant, with coaching, may then perform the rest of the treatment. The patient is seated in a chair in front of a low table. It is advisable to have the table no more than one foot higher than the seat of the chair. Since the right side is usually treated first, the patient's head is turned 45° to the right and lowered until the right side of the forehead touches the near edge of the table. The forehead—this is important—must be lower than the chin.

The patient is then given a small, shallow basin to hold in the right hand below the nose. A 10 cc. ordinary Luer syringe, to which a hard rubber, olive-shaped tip of sufficient size has been attached, is filled with a freshly (daily) prepared solution of sodium sulfathiazole (5 per cent). If there is more than average space in the nares, a 20 cc. syringe should be used. The tip of the syringe is then inserted into the right (lower) nares and the plunger pushed home. A little solution should escape

from the left (upper) nares, indicating that the cavity is filled. The patient holds the syringe sufficiently tightly to prevent leakage for five minutes. The same treatment is then used on the other side, the head turned to the left. When this is finished the patient is given several sheets of absorbent tissue and dismissed. There will be a gradual discharge of the solution over a period varying from a few hours to two or three days. The treatment is repeated at intervals of three to five days.

### RESULTS

Three hundred consecutive cases diagnosed sinusitis (acute and chronic) were given this treatment in my office and the results carefully recorded. The number of treatments given varied from one to nineteen and averaged 4.4 per patient. In those cases where there was felt to be an accumulation of pus in frontal, sphenoid or antrum, those sinuses were irrigated in addition, or an attempt made to do so.

Cases were considered cured in which three conditions were met, viz.: the symptoms relieved; no nasal or postnasal discharge reported; no pus found in the nasopharynx. Of the 300 cases, 227 were cured, 23 improved and 30 unimproved. In 20 cases results were not obtained since the patients, for one reason or another, discontinued treatments before being discharged. Of the 23 improved and the 30 unimproved cases, 27 were subsequently found to have a nasal allergy of primary importance.

### HYPERSENSITIVITY

A few patients were found who could not tolerate the treatments due to a hypersensitivity to the solutions. All patients were instructed to report any irritation during treatment to the nurse and treatment was immediately stopped. This happened in five cases. In two other cases nasal congestion, headache and rhinorrhea resulted and treatment was discontinued. Such irritation may be due to the shrinking solution or the sodium sulfathiazole or both.

### COMMENT

Were there any ill effects of this treatment in the 300 recorded cases? None except in those seven cases of hypersensitivity already noted.

Is this treatment useful in acute colds? Since there seems to be no rational argument for this it has not been tried.

Does the sodium sulfathiazole solution entirely fill the ethmoidal cells? Probably not, nor is this felt to be necessary.

Does *any* of the solution reach the ethmoidal cells? X-ray made after using an opaque media (lipiodol) indicates that it does.

How much of the solution remains in the nose after treatment? In 25 cases the amount of the solution introduced into the nose was compared with the amount collected after treatment. The largest amount retained was 5½ cc., the smallest 1 cc. and the average 2.2 cc.

### SUMMARY

In 300 cases of diagnosed sinusitis, 227 were cured and 23 benefited by the use of 5 per cent solution of sodium sulfathiazole administered by syringe with the patient in a sitting posture, head angled, forehead lower than chin. This technic is felt to be particularly indicated in the treatment of ethmoiditis.

45 Park Street

## HEMORRHAGIC COMPLICATIONS FROM SALICYLATE THERAPY

Although severe toxic reactions following salicylate therapy are uncommon, the recent interest in more intensive forms of salicylate therapy renders the report of two cases of probable fatal salicylate poisoning of interest.

The outstanding findings at autopsy were hemorrhagic changes, widespread over the body but particularly involving the brain, and severe widespread hyperemia. The explanation of these findings is probably a combination of capillary damage and hypoprothrombinemia produced by the salicylates.

It would seem that vitamin K is strongly indicated in all cases in which large doses of salicylates are administered. — Ashworth and McKemie, J.A.M.A., Vol. 126, No. 13, p. 806.

# STATE ACTIVITIES

## AMENDMENT TO CONSTITUTION

Presented at 1944 Annual Meeting. Final action to be taken at 1945 Annual Meeting.

Article VI—Board of Trustees

"The Board of Trustees shall be the executive body, and shall be composed of *the Junior Past President,* the President, President-Elect, two (2) Vice Presidents, Secretary and Treasurer (by virtue of their offices), and eleven (11) members * * *"

Alfred Stahl, M.D.,
Secretary.

## STATE OF NEW JERSEY DEPARTMENT OF HEALTH

### PENICILLIN TREATMENT FOR SYPHILIS AND GONORRHEA

The New Jersey State Department of Health provides penicillin and/or hospitalization for the following types of patients:

1. Primary syphilis (chancre).
2. Secondary syphilis (rash, mucous patches, condyloma, etc.).
3. Latent syphilis *definitely* of less than one year duration.
4. Congenital syphilis under one year of age.
5. Gonorrhea in patients who either
   a. Are resistant to at least 20 grams of sulfonamide, or
   b. Are intolerant to sulfonamides, or
   c. Have serious, acute complications of the disease (epididymitis, ophthalmia, acute salpingitis, acute arthritis).

Penicillin is also provided for ambulatory treatment of the above types of gonorrhea in clinics and physicians' offices.

Certification must be made that the patient either:

1. Cannot afford to pay, or
2. Is under isolation imposed by the health officer under authority of law.

Application blanks and recommended schedules of treatment are available at most hospitals or from the State Health Department, Trenton. If difficulty is encountered in arranging for a hospital bed, the attending physician may either write to this Department or phone (Trenton 2-2131, Extension 704) for assistance.

Some patients may refuse treatment in a hospital near home because of fear that friends who are employees of the hospital will learn of their venereal infections. Such patients may be hospitalized in other cities where they are not known.

Penicillin treatment has a profound immediate effect upon syphilitic lesions and is effective in controlling infectiousness. However, this therapy, like all other rapid forms of treatment, interferes with the development of natural immunity. Thus, whereas reinfections after "standard" (arsenic-bismuth) treatment are infrequent, with penicillin treatment reinfections are relatively frequent unless the source of infection and exposed persons are found and treated. (With gonorrhea, reinfection has always been a problem.) Therefore, with penicillin treatment contact investigation is doubly important. Physicians are urged to arrange for *all* of their venereal disease patients (regardless of income, social standing, race or sex) to be interviewed for contacts by skilled investigators, specially trained and experienced in this work. These investigators are also trained and instructed in the protection of physician-patient relationship. For information as to the availability of this service in your local community write to your State Health Department. If, after using this service, you have any complaints or constructive suggestions, please tell us about them. Only in this way can a satisfactory coöperative relationship between physician and health department be maintained for the effective protection of the public health.

## TENTH HARRISON S. MARTLAND LECTURE

The Tenth Harrison S. Martland Lecture will be held on Wednesday, March 28, 1945, at the Academy of Medicine, 91 Lincoln Park, Newark, N. J., at 9:00 p. m., under the auspices of the Essex County Anatomical and Pathological Society.

Paper: The Army Institute of Pathology and Its Contribution to the Study of Diseases Prevalent in the Military Air Group.

Speaker: Col. J. E. Ash, Director, Army Institute of Pathology, Office of the Surgeon General, Washington, D. C.

## FOUR MEDICAL EXAMINERS RENAMED BY GOVERNOR EDGE

Reappointment of four members of the twelve-man State Board of Medical Examiners for three-year terms was announced February 20, 1945, by Governor Walter E. Edge.

The reappointments, which do not need Senate confirmation, included the Drs. Earl S. Hallinger of Camden, board secretary; Arcangelo Liva of Hackensack, board treasurer; Elmer P. Weigel of Plainfield and Wendell J. Burkett of Pitman.

Dr. Hallinger's current term expired February 26, 1945, while those of Drs. Liva, Weigel and Burkett ended March 9, 1945.

## OBITUARIES

### DR. S. JOSEPHINE BAKER

Dr. S. Josephine Baker, pioneer in child hygiene and member of the New Jersey State Board of Health, died February 22, 1945, in New York Hospital at the age of 71.

Dr. Baker, who lived at Trevenna Farm, Belle Mead, was elected an Honorary Member to The Medical Society of New Jersey in 1942.

Dr. Baker, who was born in Poughkeepsie, was graduated in 1898 from the Women's Medical College of New York Infirmary. In 1907 she was appointed assistant to the New York health commissioner and the next year was named director of the city's bureau of child hygiene. In a few months she was able to show a decrease of 1200 infant deaths over a comparable period of the previous year. By 1918 a 10-year record showed the infant death rate had been reduced from 144 to 88 per 1000 births, and in 1922 the figure was lowered to 71.1. Dr. Baker was head of the bureau from 1908 to 1923. This was the first bureau of child hygiene instituted under any governmental control in the United States and was eventually copied by 35 states.

She was the first woman specialist to be named by the League of Nations to represent the United States on its health commission. In 1917 she became the first woman to receive the degree of doctor of public health from Bellevue Medical College, now part of New York University Medical School.

Dr. Baker was a member of the New York County and State Medical Societies and American Medical Association. She was a fellow of the New York Academy of Medicine and American Public Health Association. She was an Honorary Member of the Somerset County Medical Society as well as the State Society. She was former president of the American Child Hygiene Association and the American Medical Women's Association, and a consultant of child hygiene for the United States Public Health Service and United States Department of Labor. She was also a member of the Board of New Jersey State Reformatory for Women and consulting pediatrician on its staff.

Dr. Baker wrote several books and was author of many articles published in lay and medical magazines.

### DR. PERCY H. TERHUNE

Dr. Percy Hamilton Terhune, retired Passaic physician and son of the city's first mayor, died on January 25, 1945, in a hospital in New Haven, Conn., following an illness of several months.

Dr. Terhune was a former president of the Board of Health and city physician, an organizer of Passaic Hospital Association and for many years until his retirement head of the X-Ray Department of Passaic General Hospital.

Dr. Terhune, a descendant of an old Jersey Dutch family, was born in 1867. His grandfather was the first president of the Passaic County Medical Society in 1837.

Dr. Terhune was a member of The Medical Society of New Jersey, the American Medical Association, and an honorary member of the Passaic County Medical Society.

# COUNTY SOCIETY REPORTS

## ATLANTIC COUNTY

Walter B. Stewart, M.D., Reporter

The regular monthly meeting of the *Atlantic County Medical Society* was held Friday, January 12, 1945, at the Hotel Chelsea, with the President, DR. CHARLES HYMAN, in the chair.

The speaker, COL. R. E. SCOTT, M.C., Chief of the Reconditioning Facility, England General Hospital, Atlantic City, chose as his subject "Objectives in Reconditioning". Reconditioning is defined as the restoration of the individual to normal, or as nearly normal as possible, physically, mentally and emotionally. In contrast, rehabilitation means the re-establishment of earning power after the traumas of war, and is a function of the Veterans Administration.

The Army had long realized that more adequate control of supervised convalescence was needed; that pure rest often did more harm than good, permitting too much time for introspection and self-pity. The veteran became psychologically wounded. There was no urge to get back to normal. He enjoyed hospital life too much. The Personnel Section of the War Department, whose concern this problem was, took steps to shorten the average period of hospitalization of the convalescent. This work was first started by the Air Corps on a semi-voluntary basis, but has now spread to the entire Army and is largely compulsory. It is a program of supervised, controlled reconditioning. Many returnees at first say, "But I have done my bit. What's the use of all this?" Upon arrival at the Station, which here is the Hotel Traymore, each soldier starts his reconditioning program with an Orientation Course, which explains to him what it is all about.

The patients are divided into four classes. Class 4 includes those bedfast, among whom exercises are started as early as possible after arrival at the hospital, or after operation. For instance, soon after an appendectomy, the patient is started on a series of exercises of the muscles of the neck, the arms and the feet. Educational courses and talks by authorities on different subjects are given by radio phones. The patient is questioned about his previous education; his high school or college is contacted and arrangements are made whereby he is given credits towards graduation for courses given while he is in the hospital.

Class 3 is the semi-ambulant group—those who have gotten out of bed but still need hospital treatment and are in the hospital environment. They are given physiotherapy and occupational therapy.

Class 2 and Class 1 no longer require hospitalization. They wear the regular uniform and lead active lives, getting up at 5:45 a.m., having regular programs of activities, resting from 11:30 to 1:30, and retiring at 11:00 p.m. The men are placed in companies according to their ailment: e.g., nerve injuries to the arms, or foot injuries, thus receiving training which fits in well with their treatment. Each one helps indoctrinate another in his group.

There are thirty-three courses offered, including almost every activity, such as wood-work, languages, etc., thus keeping the patient busy physically and mentally and facilitating his recovery. The average stay in the hospital is shortened, for example, by fourteen days in the hernia case.

The typical convalescent soldier wants no sympathy; he wants merely to be let alone. Our purpose is to teach the man without an arm or without a leg that he is not a hopeless cripple. We fit him with a leg and teach him to drive a car or to dance, thus imparting self confidence and the will to live. Don't talk to him of his injury, but talk of anything else that may interest him. In the course of one year 6500 men have been reconditioned at this hospital and have been returned to active duty or to civilian life. The men of the latter group have been given pre-vocational training on the farm, in the wood shop, with motors or photography. All participate in games to foster the spirit of play. All are given physical fitness tests.

## BURLINGTON COUNTY

T. B. Dickson, M.D., Reporter

On February 8, 1945, the *Burlington County Medical Society* met at the Riverton Country Club.

DR. WILLIAM A. LELL, Bronchoscopist to the Abington, Episcopal, and Pennsylvania Hospitals of Philadelphia, spoke on "Early Diagnosis of Cancer of the Lung and Its Treatment". Colored lantern slides illustrated his main points. Dr. Lell also spoke on "Tuberculosis of the Larynx", illustrated by moving pictures.

At this meeting it was suggested that DR. J. HOWARD HORNBERGER become a candidate for the office of Second Vice-President of the State Society. The County Society voted unanimously to support Dr. Hornberger as a candidate for the office.

## CAMDEN COUNTY

Joseph C. Lovett, M.D., Reporter

The *Camden County Medical Society* held its monthly meeting February 6, 1945, at the Camden City Dispensary with DR. HENRY B. DECKER presiding. Thirty-four members and guests attended.

The program was a discussion of "Distribution of Medical Care".

DR. THOMAS K. LEWIS remarked the cost of medicine the past fifty years has increased, which has raised the cost to the patients. The actual annual medical cost is less than the cost of amusements, cosmetics, tobacco, etc. The independent practice of medicine should be maintained. The relationship between the patient and physician must be maintained as well as the management of our general hospitals. Local control of medical problems should not be lost. There should not be any governmental interference with medical education. Medicine must not be under bureaucratic control.

MR. ERNEST KORNFELD, secretary of the C. I. O. of this area, gave the views of labor. Organized labor

is not only interested in protecting labor in wages but also in Social Security and proper medical care. The opinion of labor is there has been no plan brought forth that will insure this better than the Murray-Wagner-Dingell bill. He did not think the bill would interfere with the conclusions of Dr. Lewis. In any event, the benefits of free practice of medicine would be exceeded by Federal Organization of Medicine.

Dr. Norman M. Scott outlined the results so far in the State of New Jersey of the Voluntary Insurance Plan. The plan was definitely reaching a group of people who would not have medical care without it. Operating costs amount to 18.9 per cent of the income. It is felt any government plan would cost more than this.

In the discussion, Mr. F. Morse Archer, Jr., said the Murray-Wagner-Dingell bill was unintelligible. The Surgeon General of the U. S. Public Health Service did not know how he would carry out the measures of the bill. The present hospital managers would not be interested in serving under government control. In closing the discussion, Dr. Lewis brought out that the medical profession had not been consulted in writing up the bill.

## HUDSON COUNTY

Harry J. Perlberg, M.D., Reporter

A regular meeting of the *Hudson County Medical Society* was held on February 6, 1945, at the Masonic Club, Jersey City. Meeting called to order by the President, Dr. Walter D. Weber, at 9:35 p. m. It was regularly moved, seconded and carried that the minutes of the regular and Executive Committee meetings be approved as printed in the February Bulletin.

Mr. Blanksteen, authorized disability insurance representative of The Medical Society of New Jersey, was invited to attend this meeting for the purpose of answering questions pertaining to the group plan of accident and health insurance that was placed before the Society under date of January 15, 1945. He reviewed the outstanding features of the Physicians' Special Policy with its non-cancellable agreement rider, which will be made available to the members of the Society provided 50 per cent of the eligible members shall have subscribed during the enrollment period, January 15 to March 15, 1945, and elucidated several points brought up for discussion.

In view of current rumors that all conventions are to be interdicted for the duration of the war, Dr. Londrigan, President of the State Society, was asked to discuss the present status of plans in connection with the annual meeting of The Medical Society of New Jersey at Atlantic City in May. Dr. Londrigan said that while the final decision still rests with the War Manpower Commission, favorable action on the application of the State Society is within the bounds of possibility for these reasons: The primary purpose of such a convention is the promulgation among Society members of information pertaining to advances in medical science, making it a health measure. In this particular instance, transportation facilities would not be taxed materially, since those who would attend the convention would not be required to travel great distances by rail, our meeting being intrastate in character. Furthermore, the attendance is about equally distributed over the three-day period. The hope was expressed that the Society will be permitted to hold its 179th Annual Meeting.

The following were elected to membership: Drs. Gerard E. DeSevo, John G. Garbarini, Joseph M. Skrypski, Joseph Grubowski, Jersey City, and Lawrence J. Urban, Bayonne.

Dr. Heins Wichman, Jersey City, transferred from the Medical Society of the County of New York.

Dr. Samuel Kleinberg, F.A.C.S., Attending Orthopedic Surgeon, Hospital for Joint Diseases, New York, spoke on "The Differential Diagnosis of Low Back Pain" with lantern slides.

In introduction, Dr. Kleinberg stated that no subject in orthopedics "offers as many obstacles and pitfalls" as does the problem of low back pain, patients presenting themselves with subjective symptoms that are very similar but prove to be of vastly different and sometimes remote origin. Utmost care and extreme caution are the keynotes in arriving at a correct differential diagnosis of pain in the lower back.

First, a detailed history of the onset of the pain and its progress must be obtained. The type of body structure and state of development must be carefully observed. In this connection, it should be noted that in an asthenic individual, back pain may be purely an expression of exhaustion from either physical or mental overwork, and is often a complaint of students and those who spend long hours reading, etc., without physical relaxation. In a physically well developed person, a truck driver for example, who eats well, sleeps well, and exercises sufficiently, the cause of pain in the lower back may be remote. In an obese individual, it may be found that the drag of adipose tissue on the lumbar spine may be great enough to cause severe discomfort. Poor posture when sitting, standing or walking is often responsible for back pain.

In a preliminary physical examination for factors predisposing to back pain, general debility is a finding of note, as is the presence of anemia or evidence of exhaustion from illness, worry or overwork. The matter of adequate rest should also be investigated. In the more detailed examination, the possibility of ureteral calculus is important, also prostatic enlargement and bleeding hemorrhoids. The presence of a cord tumor would be of significance. Cardiac decompensation would also be worthy of note, as well as abdominal tumors and uterine derangements.

If the probable etiological factor is not located elsewhere, a careful study of the back itself is indicated. The position and degree of similarity in appearance of the scapulae should be observed. The relation of the spine to the mid-line of the body should be studied, keeping in mind that the vertebral column normally occupies a median position in an unbroken physical line, at the same time maintaining its normal physiological curvature. Any area of angulation or depression must be given the benefit of special investigation. In examining the

spine for mobility, range of motion, etc., the age of the patient and his physical makeup, whether tall and thin or short and stout, should be considered—the tall, thin individual usually exhibiting greater mobility and range of motion than the short, stocky person.

In a complete examination of the spine, an x-ray examination is extremely important since many abnormalities defy detection by any other method. In addition to revealing evidence of pathology, the x-ray demonstrates congenital anomalies such as a variation in the number of ribs or vertebrae, the presence of sacralization of the fifth lumbar vertebra or of a spina bifida occulta, asymmetrical contour of the vertebrae, angulation at the lumbosacral junction, and congenital fusion of the vertebral bodies. It was pointed out that many persons go through life without any apparent discomfort from anomalous conditions. An illness, however, or even a minor injury, may give rise to troublesome symptoms resultant upon the anomaly.

In striving for a correct diagnosis in low back pain, the bony structure of the feet must not be overlooked, flatfoot being a frequent cause of pain in the lumbo-sacral region because of improper body balance.

Dr. Kleinberg discussed vertebral epiphysitis and urged that prophylactic measures be instituted whenever this tendency is observed. The patient, he advised, should be placed on a convex frame for six to eight weeks or three months, and later fitted with a proper brace.

Conditions that may exist in the soft tissues of the back are also worthy of attention, since they are found to be capable of causing "as much trouble as bones, joints and ligaments". Myalgia, myositis, myofascitis and fibrositis were included in this category.

Sprain in the lumbar, lumbosacral and sacroiliac joints, acute or chronic, was discussed as a common cause of prolonged pain and discomfort.

The speaker discussed in detail the matter of herniation of an intervertebral disc. He asserted that surgery has been unnecessarily employed in many cases wherein it was assumed that such a pathological condition existed, and such surgical intervention failed to disclose any evidence of a herniated intervertebral disc. Degeneration of the cartilage, he said, does not indicate a herniated disc. He strongly urged conservatism in the consideration of such a possibility, and cautioned against surgery except when there is definite evidence of nerve pressure and a positive diagnosis of herniated disc.

Sciatic scoliosis, another type of pathology accountable for low back pain, was defined as "a painful deformity of the back, secondary to a more or less simple lesion of the soft tissues of the back, the joints of the back, or the intervertebral discs", and said to be an unconscious expression of an attempt of the individual to relieve himself of pain.

In his discussion of spondylolisthesis, a slipping forward of the fifth lumbar body, conservative treatment was also urged, Dr. Kleinberg asserting in the light of his experience that most patients do well under conservative therapy.

Osteoporosis of the vertebrae, a thinning out of porous condition of the bone structure, due to age or faulty metabolism, also predisposes to weak or painful back. Rest and support are indicated in this condition.

Specific and non-specific inflammatory lesions of the spine and pelvis were also discussed briefly.

Fractures occurring in different parts of the spine were considered at length. Dr. Kleinberg described and showed slides of fractures of the vertebral bodies that under former methods of treatment resulted in compression deformities. Employing present methods of treatment, such fractures are permitted to unite under conditions wherein the patient is immobilized in certain positions of hyperextension that allow the fragments to occupy their normal position, thus avoiding the previously anticipated compression deformity.

Discussing fractures of the transverse processes of the spine, the speaker declared that most of these fractures "do well with treatment—or even without treatment", and usually there is no resultant discomfiture beyond a reasonable period of time unless the fragment becomes markedly separated from the main bone. He mentioned the fact that a patient sustaining such a fracture should not be told he has a "broken back", because such misinformation usually produces a psychological reaction that tends toward producing prolonged disability.

Primary tumors of the spine, benign and malignant, were also included in the presentation, with a short explanation of metastatic processes—all of which are capable of producing that most common of human ailments, pain in the lower back.

In conclusion, Dr. Kleinberg reiterated that only through a complete examination of the patient, eliminating lesions in other systems, with a careful, painstaking examination of the spine itself, including roentgenographic examination, can a correct differential diagnosis in low back pain be made.

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## MONMOUTH COUNTY

Elsworth F. Baker, M.D., Reporter

The regular meeting of the *Monmouth County Medical Society* was held on Wednesday evening, January 24, 1945, at the Nurses' Residence, Fitkin Memorial Hospital, Neptune. The reading of the minutes of the last meeting was dispensed with due to the lateness of the hour.

The following business was transacted:

1. The application of DR. HELEN DIMITROW was approved for membership in the Society.

2. The MAJOR EDMUND KANSES MEMORIAL FUND, originally discussed at the September meeting, was finally approved in revised form providing for a plan whereby the returning physicians may apply to a local bank for a quick loan amounting to $300 to $500 and the Society will pay the interest on the loan. It was not felt necessary nor wise that the Society should attempt to raise funds to cover possible loans; first, because such a large fund would be necessary and might remain indefinitely idle, and, second, large sums of money can be borrowed

at a low rate of interest from the Federal Government. The need of the returning physicians would be mostly to obtain a small amount of money quickly until other arrangements could be made. It was suggested that the members contribute $25.00 a year for two years which would raise approximately $2500, a sum adequate to pay any interest on loans outstanding. The Secretary was authorized to put this plan into effect.

3. The problem of nursing economy was discussed and a letter from Procurement and Assignment was read. It was agreed that the Society should go on record as endorsing group nursing and the discontinuation of luxury nursing and that letters be sent to the Nurses' Alumni Association of the Hospitals in the County and to the Superintendents of these hospitals expressing the attitude of the Society in these matters.

4. President Dr. Otto Holters has for some time been interested in securing available blood and plasma for indigent patients and has suggested that some program be outlined whereby available funds could be obtained to pay for this blood. It was decided that the Woman's Auxiliary be asked to create a blood donor fund for this purpose.

DR. LOUIS F. ALBRIGHT gave a short but comprehensive and very interesting talk on several cases he had under treatment at the present time. The first was a case of strain thrombosis of the axillary vein in the left arm occurring in a 43-year-old previously healthy woman. She gave a history of having opened a frozen window five days previously and had developed swelling in the left arm. She was treated by rest, elevation of the arm and Dicoumarin. She has shown a very satisfactory convalescence. Dr. Albright discussed the method of gauging results of Dicoumarin by the pro-thrombin index. He next discussed three cases of hyperthyroidism treated with Thiouracil. The first, a case of toxic adenoma who was placed on Thiouracil for a period of six weeks with a gradual drop in the basal metabolic rate and pulse rate. Twelve days prior to operation, she was placed on Lugol's solution and showed a normal convalescence following her operation. Two cases of non-ademotous hyperthyroidism (Graves disease) in which Thiouracil was used without other therapy. This drug does successfully reduce the basal metabolic rate, patients gain weight and their pulse rapidly returns to normal. These two cases of Graves disease have done very well but one has to look for the possibility of toxic effects of the drug which are similar to the sulfonamid drugs in general, the most important of which is the development of agranulocytosis. This treatment may answer the problem in these cases without operation.

Dr. Harold H. Freedman, in discussing this treatment, felt that we should still be cautious as some deaths had been reported, and emphasized that it is necessary to watch the patients very closely for the first six weeks. They should be seen daily and a blood count done at least once a week. He felt that there was much less danger of toxic effects by the use of small doses of not more than 0.6 grams per day as opposed to some clinics recommending up to 2 grams per day.

## PASSAIC COUNTY

J. Reuben Budd, M.D., Reporter

The regular monthly meeting of the *Passaic County Medical Society* was held at the County Court House, Paterson, on January 15, 1945. This was a joint meeting with the Passaic County Bar Association. The program consisted of a debate on the Wagner-Murray-Dingell Bill.

The affirmative was taken by THEODORE SANDERS, M.D., Counsel to the Physicians Forum, and LEO J. LINDERS, ESQ., Vice-President of the National Lawyers Guild, New York Chapter. The negative was taken by LOUIS H. BAUER, M.D., member of the Board of Trustees of the American Medical Association, and the HON. WILLIAM W. EVANS, former President of the New Jersey State Bar Association.

This meeting was publicized by press and radio and among those present were many laymen who were apparently vitally interested in the subject. There was a brief discussion following the debate.

DR. ANDREW MCBRIDE, one of the deans of the medical profession in Passaic County and a close student of medical-economic legislation, felt that the medical profession should be justly proud of its coöperation with all agencies, government and private, in giving care to those in need and unable to pay for that service. Services and medicines to the sum of many millions of dollars have been given without charge by physicians each year without public statement or record. No one in need of medical care and making that need known to the proper officials of government or private agencies or directly to physicians should have failed to receive medical service. He expressed the opinion that any radical change in our present form of medical practice should not be entertained while so many of those involved by the change are now serving in the armed forces.

## UNION COUNTY

Norman W. Burritt, M.D., Reporter

The regular meeting of the *Union County Medical Society* was held at the Elizabeth General Hospital, Elizabeth, on January 10, 1945. The meeting was called to order by DR. BENSLEY, President, at 9 p. m.

The minutes of the November 8, 1944, meeting and the minutes of the Executive Committee meeting of January 8, 1945, were read and approved. The resolutions on the death of CAPT. EDWARD J. HACKETT, M.C., were accepted as read by the Secretary.

DR. GLENN S. USHER, Chief of the Bureau of Venereal Disease Control of the State Department of Health, was the speaker of the evening. A film on syphilis was shown. It emphasized the early diagnosis and treatment of the disease. Dr. Usher also discussed the penicillin treatment of syphilis and gonorrhea. An interesting discussion followed.

MAJOR JOHN J. HAMLEY, M.C., of Elizabeth, who is now home on leave after serving in the Indo-China area for two years, discussed some of the phases of disease control among the armed forces in that region.

DRS. G. A. EADIE of Westfield, MAX PREMINGER of Plainfield and R. A. YOUNG of Linden were elected to membership.

# WOMAN'S AUXILIARY

## PRESIDENT'S MESSAGE

Mrs. David B. Allman

"Never did so many owe so much to so few." Thus spoke Prime Minister Churchill after Dunkirk. Would it not be fitting and proper if our colleagues and their wives, upon returning from service, could truthfully paraphrase that expression as applied to the work done by our Auxiliary during their absence.

True we have accomplished much during the past year. This fact is forcibly brought to me as I travel through the various component counties and visit their splendid Auxiliary meetings. But, by united effort, much more can be done to strengthen the hand of Organized Medicine in New Jersey, and to make the lot of our medical returnees a little easier and a bit more pleasant.

Never before has our Auxiliary had such splendid coöperation from The Medical Society of New Jersey. Can we do less than our best to show our appreciation?

Much of the program of our State Auxiliary, as proposed at the beginning of my term of office, has been successfully advanced. A few members have not been as diligent in some matters as they might have been. As this Auxiliary year draws to a close, let us each individually vow to lend every effort to those things that will keep American Medicine on its high pedestal, so that upon their return the Medical Men of New Jersey can say of us in unison, "Well done, Good and Faithful Servants".

## HISTORY AND ARCHIVES

Mrs. C. Chester Chianese, Chairman

In preparation for the Annual Meeting of the Woman's Auxiliary to The Medical Society of New Jersey, it is requested that each County Historian compile a brief history of her County Auxiliary during this year. It is important that these reports include the following data in particular:

1. Names of officers.
2. Number of meetings.
3. Increase in membership and reason.
4. Specific work assigned by your County Society.
5. Philanthropic endeavors and amount raised.
6. Social activities and purpose.
7. Work in—
   a. War Participation.
   b. Legislative Program.
   c. Public Relations.
   d. Medical Histories.
   e. Hygeia and Bulletin.
   f. Physicians Aid Society.

These records should be dated and signed by the President and Historian. Prepare two copies; keep one for the County Archives and mail the other to the State Historian. This office in turn will compile the 1944-1945 State Auxiliary History. All documents will be permanently stored in the new home of The Medical Society of New Jersey for future reference when again we are called upon by the national organization for a second Book of New Jersey Medical Auxiliary History.

Affix the necrology of the year to your County report for the Memorial Book. Save clippings and notices as evidence.

It is the aim of the History and Archives Committee to preserve an accurate written account of facts and events, and of all worthwhile undertakings and accomplishments of our organization. We are experiencing one of the outstanding periods of history-making and the Auxiliary has some part in this world's work.

"The effort of the day brings its sure reward."

## FUTURE EVENTS

Atlantic—The Madison Hotel will be the next meeting place of the Woman's Auxiliary, April 13, 1945, at 2 p. m. Mrs. Charles Hyman will be Program Chairman.

Essex — On Tuesday, March 27, 1945, the Woman's Auxiliary will be the guests of The Contemporary Club of Newark at the Contemporary Clubhouse, 605 Broad Street, Newark. Dr. William Nyiri will speak on "Health of Tomorrow".

On Monday, April 9, 1945, at 2:30 p. m. at The Academy of Medicine in Newark the Woman's Auxiliary will hold a symposium on Child Health. This is the third in a series of symposia on problems of community interest.

Gloucester—On Thursday, April 26, 1945, the Woman's Auxiliary will hold a Reciprocity Tea. Dr. Frederic Quigley will speak on "Socialized Medicine".

Hudson — On Monday, April 2, 1945, the Woman's Auxiliary will hold its Installation of Officers at 1:30 p. m. at the Y. W. C. A. in Jersey City.

Middlesex — At 8:30 p. m. on March 21, 1945, at the home of Mrs. L. A. M. Feher of 177 Somerset Street, New Brunswick, the Woman's Auxiliary will hold a regular business meeting.

Monmouth — The Woman's Auxiliary will hold a luncheon meeting on March 13, 1945, with Mrs. David B. Allman, President of the State Auxiliary, as the guest of honor. Following the luncheon Mrs. Allman will speak of the work of the State Auxiliary and of the County Auxiliaries.

## AUXILIARY REPORTS

### Atlantic County

Mrs. Samuel Salasin, Chairman of Publicity

An enjoyable program was presented following a brief business meeting of the *Woman's Auxiliary to the Atlantic County Medical Society,* held Friday night, February 9, 1945, at the home of Mrs. William Roop. Mrs. Daniel C. Reyner, President, conducted the meeting.

Mrs. Roop presented the program, which included a talk by Lt. Esther G. Skelley, whose topic was "The Privilege of Being an Army Nurse". Lt. Skelley quoted General Sherman in saying that "An Army has soul as well as a man" and added that the "soul" is the Army nurse. She is the one who is at the injured soldier's side shortly after his injury, and it is to her he turns for physical care and moral support.

The musical portion of the program included songs by Miss Mary Roop, piano selections by Mr. Jack Reyner and songs by Miss Nancy Lawther, with Miss Doris Jacoby accompanying.

### Camden County

Mrs. Lawrence Glover, Chairman of Publicity

On February 13, 1945, the *Woman's Auxiliary to the Camden County Medical Society* held a panel discussion on "This Year's Medical Legislation" at 2 p. m. at the home of Mrs. Joseph E. Roberts, Haddonfield.

### Essex County

Mrs. Rocco Marra, Chairman of Publicity

The *Woman's Auxiliary to the Essex County Medical Society* held its Symposium on Postwar Problems of Community Health, the second in a series of symposia, on Tuesday, January 23, 1945, at the Academy of Medicine. The Auxiliary President, Mrs. Lodovico Mancusi-Ungaro, presided. Mrs. S. Bernard Kaplan, Chairman of Public Relations, presented the speakers.

Guest speakers were: Lt. Col. Stuart Z. Hawkes, Chief of Surgical Service, Army Air Force Convalescent Center and Regional Hospital, Mitchell Field; Dr. Aaron H. Haskin, Medical Investigator for the City Health Department, and Mrs. Richard H. Bethel of Montclair, President of the Welfare Council of New Jersey.

Col. Hawkes cited the attitude of community representatives who seek to aid returning servicemen suffering disabilities. He told of Army methods of handling soldiers in rehabilitation centers and individualized treatment. Effort is made to bring the man as nearly as possible to his former condition, Col. Hawkes pointed out, and to prepare him for problems in readjustmet to civilian life. He urged civilians in dealing with returning soldiers not to take "You poor boy" attitude, do not stare at him or ask him questions about his war experiences and do not give him charity. The speaker urged tolerance and effort to make the soldier reliant; support him without his knowing it and treat him as if he were normal.

Dr. Haskin told of the City Health Department's readiness to assist physicians in dealing with men returning with tropical diseases. Malarial infections are not likely to be as much of a problem as was at first expected, Dr. Haskin said. The city has trained technicians who will be able to help when needed and can make analyses in city laboratories.

Mrs. Bethel stressed value of public and private agencies coöperating in postwar work and need of community councils to coördinate welfare activities. Army and government have worked well in postwar planning, but communities have much to do, the speaker said. "I believe," Mrs. Bethel said, "that the community should adjust itself to the veteran rather than the veteran to the community. He has been adjusting himself ever since his induction."

On Wednesday, January 24, 1945, Mrs. Louis Schneider, wife of the President of the Essex County Medical Society, gave a tea at her home for the Auxiliary. Harp selections were played through the afternoon by Miss Dorothy Coy.

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**Gloucester County**

Mrs. C. A. Bowersox, Chairman of Press and Publicity

The *Woman's Auxiliary to the Gloucester County Medical Society* held a special meeting called by the President, Mrs. Henry B. Diverty, of Cooper Street, Woodbury, on Thursday, January 18, 1945, at 9 p. m. Eight members were present.

The Refreshment Committee met at Mrs. Hughes' home on Friday afternoon, January 19, 1945, with Mrs. Fred Faux as chairman.

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The *Woman's Auxiliary to the Gloucester County Medical Society* held a "Husbands' Party", Thursday evening, February 1st, at the home of Mrs. J. H. Hughes, North Broad Street, Woodbury. Mrs. H. B. Diverty, President of the Auxiliary, extended a welcome to twenty-five guests and members present.

Mrs. Fred Faux, Chairman of the Entertainment Committee, introduced Mr. Marshall Diverty, who presented his excellent, colored motion pictures of the Canadian Rockies. The pictures and commentary remarks were enjoyed thoroughly by the audience.

Following a buffet supper was served by the committee, including Mrs. C. Bowersox, Mrs. H. Diverty, Mrs. F. Faux, Mrs. J. H. Hughes and Mrs. P. Pegau.

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**Monmouth County**

Mrs. Maxwell Colby, Chairman of Publicity

The *Woman's Auxiliary to the Monmouth County Medical Society* held a meeting on February 13, 1945, at the Auxiliary Hall of Monmouth Memorial Hospital, Long Branch. Mrs. Joseph Bossone presided.

Plans were discussed for a card party and fashion show to be held in April to raise funds for the Monmouth County Blood Bank.

It was decided that the Auxiliary would hold a luncheon meeting on March 13, 1945, at which Mrs. David Allman, State Auxiliary President, will be guest speaker.

Following the business session refreshments were served by the hostesses, Mrs. Arthur Strauss and Mrs. Raoul Pietri.

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## BOOKS RECEIVED FOR REVIEW

YEAR BOOK OF INDUSTRIAL AND ORTHOPEDIC SURGERY. Ed. by Charles F. Painter, M.D. Pp. 432, illustrated. Chicago, Year Book Publishers, Inc. 1944. $3.00.

TEXTBOOK ON PATHOLOGY OF LABOR, THE PUERPERIUM AND THE NEWBORN. By Charles O. McCormick, A.B., M.D., F.A.C.S. Pp. 399, with 191 illustrations including 10 in color. St. Louis, C. V. Mosby Company. 1944. $7.50.

APPROVED LABORATORY TECHNIC: Clinical Pathological, Bacteriological, Mycological, Virological, Parasitological, Serological, Biochemical and Histological. By John A. Kolmer, M.S., M.D., Dr. P.H., Sc.D., LL.D., L.H.D., F.A.C.P., and Fred Boerner, V.M.D. 4th ed. Pp. 1017, illustrated. New York, D. Appleton-Century Company. 1945. $10.00.

INTERNAL MEDICINE: Its Theory and Practice in Contributions by American Authors. Ed. by John H. Musser, B.S., M.D., F.A.C.P. 4th ed. Pp. 1518, illustrated. Philadelphia, Lea & Febiger. 1945. $10.00.

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## BOOK REVIEWS

(The) **Kenny Concept of Infantile Paralysis and Its Treatment.** By John F. Pohl, M.D., and Sister Elizabeth Kenny, with a foreword by Frank R. Ober, M.D. Pp. 366. Minneapolis, Bruce Publishing Company. 1943. $5.00.

A distinct service is rendered by the publication of this book in that it gives the opponents and proponents of the Kenny concept a clearer definition of the debatable issues.

It states that the basic principles of the Kenny concept of the disease are "built upon the observations of the behavior of the musculature following an attack of the disease", i. e., upon the observations of muscle spasm, alienation (neuromuscular dissociation), and incoördination of muscle action. Upon these findings are built the following basic principles:

1. The affected muscles are painful, hyperirritable and in spasm.

2. The flaccid muscles are normal. Loss of ability to contract these is due to functional dissociation (alienation) from the nervous system.

3. Ability to voluntarily contract the non-functioning muscles returns only after releasing spasm in the opponents and carefully restoring the physiological continuity of the nerve conduction paths back to the muscles.

4. Paralysis due to nerve cell death occurs but is not a common condition. Most supposed weakness is due to untreated spasm and to disuse in the dissociated muscles.

5. Incoördination of muscle action appears in the untreated case.

6. Deformities do not occur. Those resulting from the old methods were due to untreated muscle spasm.

Muscle spasm (not paralysis) is considered the primary and most damaging lesion, and muscle tissue as well as nerve tissue is considered to be directly affected by the disease. Dr. Pohl states that "orthodoxy has largely been devoted to treating normal muscles and has failed to recognize the true condition in the muscles affected by the disease".

In the introduction Dr. Pohl states, "Needless to say, the treatment could have nothing in common with the previous methods, designed for a disease of opposite conception."

In the acute stage the Kenny method of treatment simulates immobilization by placing the patient on a bed with a fracture board under a firm mattress, with the feet in dorsiflexion against a footboard and with the body maintained in the alignment of normal standing posture. (The use of splints during any stage of the disease is condemned.) Moist hot foments are applied hourly for twelve hours daily until the acute muscle spasm disappears and thereafter every two hours until all muscle spasm ceases.

Muscle reëducation, guided by highly trained technicians, secluded with the patient, is carried out with meticulous instruction of the patient in muscle anatomy and proper muscle action, as well as in cerebral effort to direct efferent impulses to the muscle during passive, and ultimately, active motion. Once voluntary motion is properly accomplished, coördinated and synchronous use of the muscles is taught. The detail of these procedures merits high commendation.

The Kenny concept of infantile paralysis is considered by many leading scientists and recognized authorities on infantile paralysis to be completely erroneous. The following studies reaffirm the scientific principles supporting the orthodox concept of the genesis of the manifestation of infantile paralysis and discredit the Kenny concept, based upon observations of muscle behavior:

1. The chronaxia studies of Moldaver. (Sponsored by the National Foundation for Infantile Paralysis, Inc. J. Bone and Joint Surg., Jan. 1944.)

2. The electromyographic studies of Schwartz et al. J. Am. M. A., Nov. 11, 1944, and July 18, 1942.

3. The electromyographic studies of Watkins et al. J. Am. M. A., Sept. 25, 1943.

4. The pathological studies of Sabin. J. Am. M. A., Oct. 17, 1942.

Final evaluation of the Kenny method of treatment has not been made. A. Bruce Gill (Jour. Bone and Joint Surg., Jan. 1944) describes a close analogy of the Kenny method of treatment to the orthodox method. At the present time it appears doubtful whether any part of the Kenny concept, that is contrary to the orthodox teaching, will merit final acceptance. Daniel E. Kavanaugh, M.D.

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**Textbook of Medicine by American Authors.** Ed. by Russell L. Cecil, A.B., M.D., Sc.D. Associate editor for Diseases of the Nervous System, Foster Kennedy, M.D., F.R.S.E. 6th ed. Pp. 1566, illus. Philadelphia, W. B. Saunders Company. 1943. $9.50.

This textbook of medicine was the first readable book of its kind to be published, and it continues to be one of the most workable and convenient quick reference books in the field of medicine. This does not mean that it is abbreviated, or that various subjects are not fully covered; on the contrary, it is most complete.

The contributors have written concisely, simply, and as men who are trained in telling effectively to others what they themselves know. As usual, the names of new contributors are those of outstanding clinicians and research workers, most of them teachers.

The parts of the book which have been rewritten or revised have been improved, amplified, and brought up to date. A textbook of medicine that is not adequately revised at reasonable intervals quickly becomes outdated. The new format is a great improvement over the full page spread, and makes reading surprisingly easier, without adding to the bulk of the book.

One of the valuable features of this edition is the introductory chapter to the major sections. These introductions provide a general survey of the subject to be treated in the section. such as diseases of the cardiovascular system, diseases of metabolism, and others. In these introductions, emphasis is placed upon physiology and pathologic changes in physiology underlying or resulting from the disease to be discussed in the following pages. To this reviewer's way of thinking, this innovation is one of the most attractive and worthwhile features of this edition.

It seems that it is impossible to adequately illustrate a textbook of medicine, and while the illustrations in this are better than those in the last edition, yet they could as well have been omitted except for charts and tables.

The sixth edition of Cecil's Textbook of Medicine is exactly the sort of book that every practising physician needs to have at all times within easy reach. Harvey M. Ewing, M.D.

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**The Story of a Hospital:** The Neurological Institute of New York, 1909-1938. By Charles A. Elsberg, M.D. Pp. 174. New York, Paul B. Hoeber, Inc. 1944. $3.50.

This is the saga of the founding and development of a hospital dedicated to the study and treatment of diseases of the nervous system. At its inception it was a new idea for the country but by devotion and energy the reputation of the hospital has grown apace with enlarged quarters and acceler-

ated research. An interesting commentary on the growth of a branch of medical care.

Carolyn Valentine, B.S.

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**Modern Clinical Syphilology:** Diagnosis, Treatment, Case Study. By John H. Stokes, M.D.; Herman Beerman, M.D., Sc.D. (Med.); Norman R. Ingraham, Jr., M.D., and Associates. 3d ed. Pp. 1332 with 911 illustrations. Philadelphia & London, W. B. Saunders Company. 1944. $10.00.

If through some alchemy the contents of this magnificent book could be distilled into the minds of all practicing physicians a large portion of the frustrations of the venereal disease control officer would vanish. In support of this statement witness the following quotation from this book: "There can be no escaping the conviction after a study of this problem that the most serious difficulty confronted by a venereal disease program in a country such as the United States, where a large proportion of patients with syphilis receive treatment at the hands of private physicians, is that of raising the physician's standard of knowledge and technic to that of the modern clinic or above it."

The previous editions of this book have provided the standard text book and reference book on syphilology for eighteen years. The authors state that in this edition approximately 75 per cent of the text has been rewritten. Two new chapters have been added, one on public health and military medicine and the other describing current developments—namely, penicillin therapy and the new arsenical detoxicants. It is unfortunate that penicillin therapy is too new and the valuation of its effects on syphilis as yet too incompletely evaluated for this information to have been integrated throughout the text of the book. However, the last chapter provides for the interested practitioner up-to-the-minute data and conclusions on this important subject.

The chapter on public health and military medicine conforms with the high standard of excellence of the entire book. In speaking of the grand strategy of the venereal disease control program the authors make the following very pertinent statement: "Impressed with the value of such central policy, one is apt to lose his awareness of the fact that local conscience and local practice provide the really lasting foundation of successful venereal disease control. No central policy directive such as this can entirely take the place of the way the home folks feel about it." It is encouraging to note that in the authors' judgment public health practice in venereal disease control has progressed to a point deserving the confidence of all physicians; thus "To provide the patient with even the phraseology with which to approach his contact, to meet the family complications where infidelity has occurred, through established roundabout approaches to a problem seemingly insurmountable directly, may require more time and ingenuity than the physician cares to give to it. In such case, absolutely no hesitation should be felt in requesting the city or state authority to supply a confidential investigator. Modern practice has achieved a sufficient dependability so that no one's interest will be violated by such an intervention." Again, "The community resources available for contact-tracing and case-holding are numerous and complex, and are enumerated below. The practicing physician who senses the need for study of other members of the family, for example, may appeal to another physician who knows the family better than he does, but when the investigation gets beyond this point, he is wisest to ask his city or state health authority for the assistance of a confidential investigator."

One disadvantage with as complete and exhaustive a treatise as this is that its very bulk is likely to discourage the practitioner who is in need of the information contained therein. Every physician, however, regardless of his special field of interest, should take the time to read and absorb the sections on interpretation of blood tests and on the management of latency and of patients with fixed positive serology. The importance of spinal fluid examinations is, of course, emphasized again and again.

A text of this kind provides little opportunity for a display of the refreshing style of writing of which Stokes is capable. The reader does, however, obtain occasional glimpses of it, as in the following: "Don't treat even the most eligible and willing latent patient beyond the standard for early syphilis. Refuse to be a party to robbery or aggravated assault and battery—even in the name of a positive serologic reaction and the patient's demand for 'A pure blood'."

It is repeatedly apparent that the authors are pleased with the progress that has been made in syphilology and venereal disease control since the publication of previous editions. An example of this is with respect to the treatment of cardiovascular syphilis which has been greatly clarified and systematized. The preface ends with the following happy note: "We may perhaps take comfort and courage, however, in the way in which a book like this records the impending extinction of a centuries old plague in the short space of two decades; and reflects the advance in mankind's most noble war—the battle to achieve the ideal—'Mens sana in corpore sano'."

This book is highly recommended.

Glenn S. Usher, M.D.

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**Intern's Handbook:** A Guide, Especially in Emergencies, for the Intern and the Physician in General Practice. By Members of the Faculty of the College of Medicine, Syracuse University, under the direction of M. S. Dooley, A.B., M.D., and Maynard E. Hilmes, M.D., F.A.C.P., co-chairmen, Publication Committee. 3d ed. Pp. 579. Philadelphia, J. B. Lippincott Company. 1944. $3.00.

Since many of our hospitals are under-staffed in resident and attending physicians, this book is especially timely. The intern will find the book a reliable guide in the new situations that he will meet many times. The desired information is short and concise.

There are two sections which the intern will espe-

cially like: One, endocrinology (preparations are discussed and evaluated); second, standard drugs (action, uses, dosage and best methods to prescribe are covered).

The book is divided into five parts:.part I, Relationships; part II, Laboratory Medicine; part III, Medicine; part IV, Surgery, and part V, Therapy.

It is highly recommended.

Marvin Oransky, M.D.

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**Medical Uses of Soap: A Symposium.** By G Thomas Halberstadt, B.S., Ch.E.; Marion B. Sulzberger, M.D.; Theodore Cornbleet, M.D.; Lester Hollander, M.D.; C. Guy Lane, M.D.; Daniel J. Kooyman, Ph.D.; Rudolf L. Baer, M.D.; Carey McCord, M.D.; Morris Fishbein, M.D., and Irvin H. Blank, Ph.D. Edited by Morris Fishbein, M.D. Pp. 182 with 41 illustrations. Philadelphia, J. B. Lippincott Co. 1945. $3.00.

A collection of medical articles on the uses of soap. Chapters include the chemistry of soap, new detergents, mechanism of soap action and up-to-date methods of manufacture in line with the continuous improvements in soaps and soap products. Usual and unusual effects of soap on the "normal" skin are discussed at some length by such authorities as Sulzberger and Baer. Care of the hair and scalp, both of infants and adults, is ably covered in several chapters. Use of soap in industry, a field of special interest today, soap for shaving and finally miscellaneous uses of soap are included. The last chapter includes a discussion of the use of soap for first aid, venereal diseases, scabies, general hygiene and adds a bit about all-important shortages of this necessary medicinal aid.

The book is excellent for reference work and of special interest to the dermatologist and industrial physician. Carolyn Valentine, B.S.

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**The Avitaminoses:** A Textbook on the Chemical, Clinical and Pathological Aspects of the Vitamin Deficiency Diseases. By Walter H. Eddy, Ph.D., and Gilbert Dalldorf, M.D. 3d ed. Pp. 438 with chemical formulae, tab'es and illustrations. Baltimore, The Williams & Wilkins Company. 1944. $4.50.

This book is a MUST for all students who are interested in internal medicine or nutrition. A thorough discussion is made of the chemical, clinical and pathological aspects of the vitamin deficiency diseases.

A knowledge of the nature and functions of the various vitamin compounds is thoroughly exposed. A comprehensive table is contained in the book which explains the value of the different vitamins represented in various foods. The chapter on *The Vitamins and Infectious Diseases* is effectively discussed. The chapter on *Vitamin Assay Methods* is vague and indefinite. It is of no particular use to the reader. This chapter could have been much more practicable.

An extensive bibliography shows the amount of effort that the authors expended compiling their material. While the general practitioner will find this book of little value, it is, however, the best book that has been written on this subject thus far.

S. William Kalb, M.D.

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**Patients Have Families.** By Henry B. Richardson, M.D., F.A.C.P. Pp. 408. New York, The Commonwealth Fund. 1945. $3.00.

The foundation of this book is based largely on the Family Study conducted coöperatively by the faculties of public health, medicine and psychiatry of Cornell University Medical College, the New York Hospital and its Social Service Department and the Family Service and Department of Educational Nursing of the Community Service Society. Its object was to secure a better understanding of the family unit in medical care and indications for treatment. Non-technical language is used to describe family patterns that appear in connection with different illnesses, and indicates their significance to the physician in diagnosis and treatment. The author shows the value of pooling various services of the hospital and of the community to get a complete picture of the patient and his family, and shows how such coöperation can improve medical practice and enrich medical education.

Carolyn Valentine, B.S.

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**American Medical Practice in the Perspectives of a Century.** By Bernhard J. Stern, Ph.D. Pp. 156. New York, The Commonwealth Fund. 1945. $1.50.

A story of the reciprocal interplay between social, technological and economic forces and medicine. Against the background of social and industrial conditions of the nineteenth centry is placed the medical education and practice of the period. The evolution of the social and economical world of today and the effects which the growth of machine production, industrial urbanization and economic concentration have on the health of the people is traced. The author also sketches the concurrent growth of the science of medicine, the increasing costs of its services, the increasing duration and costliness of medical education, the growth of specialization, the phenomenal development of the modern hospital and the extent of the present distribution of medical care.

Carolyn Valentine, B.S.

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**Chemistry and Pharmacy of Vegetable Drugs:** Dealing with the Derivation and Properties of All the Principal Vegetable Drugs. By Noel L. Allport, F.I.C. Pp. 252. Brooklyn, New York, Chemical Publishing Company, Inc. 1944. $4.75.

Designed to answer the questions which arise in the minds of those interested in pharmacy, pertinent discussions of the numerous drugs in this group are introduced and directions for their general preparation are given. Drugs are so arranged as to give the reader a relative value of those of secondary importance, compared with the more important ones. The author believes that while the newer drugs are commanding attention, very few of the medicaments of vegetable origin have been displaced by them, hence it is essential for the medical practitioner and pharmacist to acquire this knowledge. Carolyn Valentine, B.S.

Volume 42
Number 3



# Tuberculosis Abstracts

## *A Review for Physicians*

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

**Vol. XVIII** **March, 1945** **No. 3**

THE proper feeding of patients in tuberculosis hospitals is a difficult task at best. Supervising an adequate diet for patients treated at home calls for even greater ingenuity. With wartime shortages and increasing costs the problem in either case is further intensified. The importance of nutrition as an aid to therapy and a factor in maintaining patient morale must not be overlooked or underestimated.

### DO WE FEED TB PATIENTS PROPERLY?

Has the pressure of the war changed our feeding of the tuberculous patient? Is a relaxation of our policy of "plenty of good food" of serious concern in the treatment of tuberculosis? What should be the goal of the dietitian in planning the wartime diet? These are questions in the minds of those interested in the care of tuberculous patients.

Personal observations have indicated that the standards of nutrition have been relaxed in some institutions, partly because of expense and, at times, because of scarcity. How general this lowering of standards has become is not known, but it is thought to be considerable.

In order to assess the significance of relaxing the policy of "plenty of good food" we must know the nutritive status of "well fed" tuberculous persons before the war. Nutritional surveys have shown that many tuberculous persons, even those on a good sanatorium diet, were actually malnourished, especially in respect to ascorbic acid and vitamin A. Other food deficiencies were also found. These observations came as a surprise, for clinicians felt secure and were worried about malnutrition only where intestinal disease obviously interfered with assimilation of food.

How important are vitamins A and C in the resistance to tuberculosis? This cannot be answered as yet, but some evidence has been obtained in favor of increasing the intake of these two substances. The cod liver oil and tomato juice "cocktail" prescribed by some in the treatment of tuberculosis is rich in these vitamins. It has been found effective in preventing the development of extrapulmonary tuberculosis in those with the disease in the lungs.

Empirical use of cod liver oil and tomato juice now has a scientific basis. We still do not know the effect of completely abolishing the deficiencies of vitamins A and C or the effect of abolishing all nutritional deficiencies.

During the last war, an experiment was unknowingly conducted on the effect of food on the resistance to tuberculosis. Before the allied blockade of Denmark was complete, much food was sold to Germany for high prices. The latter stimulated sales to such an extent that the Danes were depriving themselves of essential food, so much so that vitamin A deficiency was evident clinically and its ocular manifestation, called xerophthalmia, was found in hundreds of infants.

At this time the death rate from tuberculosis had risen to a wartime high. Later, as a result of the submarine blockade and food rationing, essential foods were left in the country. Tuberculosis began to recede as soon as exports stopped. This is now regarded as a classic observation on the effect of food, for other factors such as crowding, poor housing, fatigue and overwork were still present and unchanged. Xerophthalmia disappeared, too, when the food exports stopped.

The evidence, then, at present is that tuberculous persons are often not well nourished even when "well fed" and that malnutrition is a vital factor in the incidence and course of the disease. Such evidence makes any relaxation of our feeding standards in wartime seem hazardous.

We have learned, too, that it is not the energy content of food that is important. No doubt the Danes replaced the essential food shipped off with food of an equal caloric content. The foods shipped were those high in protein, fats, vitamins

and minerals. The substituted food was largely carbohydrate. This focuses our attention on the individual food constituents. What are the important food constituents for the tuberculous person?

Recent appraisal of the nutritional status of the tuberculous patient has brought out that these people are mainly in need of vitamin C, vitamin A, protein and minerals. The requirement of vitamins A and C is so great that it seems impractical to plan a diet with sufficient amounts of these materials to overcome the deficiencies. This then is a problem of therapeutics—the supplemental dose to be governed by the degree of the deficiency.

The diet for the tuberculous person should have an abundant amount of protein—70-100 grams per day. This is in excess of that recommended for healthy people, for the tuberculous person has to replace his depleted stores of protein, and, too, his daily needs are more.

All vitamins are probably needed in greater amounts by the tuberculous person, but we have scientific data only for a few of them. Vitamin D has been singled out for special attention because of its role in calcium assimilation and metabolism. Vitamin K deficiency has been found in tuberculous persons and is of especial concern because of its function in normal blood clotting. Those in need of vitamin K are subject to severe hemorrhages. Part of the inanition in tuberculous persons may be due to lack of the B vitamins. Minerals and calcium in particular are deemed important in the healing process. Phosphorus and iron are thought to be needed in greater amounts by the tuberculous person; phosphorus is utilized with the calcium; iron is necessary in the production of hemoglobin. Secondary anemia is always present in advanced tuberculosis.

The proper diet can be summarized as high in essential foods and low in carbohydrates. The total caloric intake is governed by the amount of carbohydrates given. When the person has gained to approximately his normal weight, the caloric intake should be reduced, leaving the intake of the prescribed essentials the same. The latter should be changed only because of food intolerances and then only after all means of substituting foods have been exhausted. The dietitian's problem is to get the prescribed amounts of the food constituents into meals that will be consumed and tolerated by the patient. It is no easy task.

The diet can be "low cost" and yet provide the essentials. The author and his associates have recommended for persons taking treatment at home a list of reasonably priced items: "Food for Tuberculous Patients." (Prepared by the Division of Nutrition, Pennsylvania Department of Health. To obtain copies of the food list communicate with your tuberculosis association.)

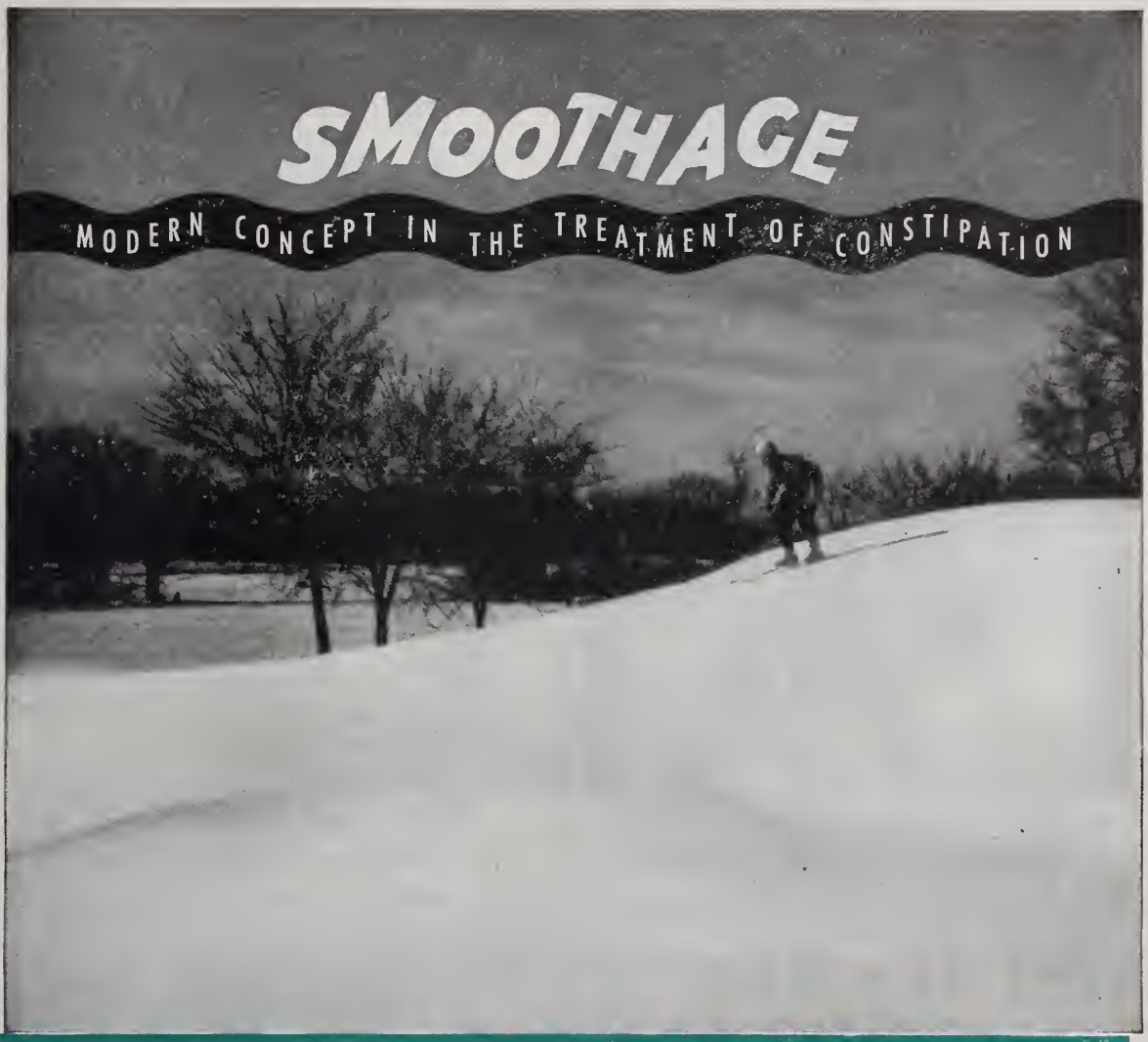
An analysis of such a food list recently concluded by the Henry Phipps Institute, Philadelphia, Penna., showed the total cost to be $4.69 per person per week. It is obvious that this removes cost as an objection to maintaining the quality of the diet. We are more anxious than ever before to get the tuberculous person well because of the wartime necessity for conserving manpower. Therefore, it is imperative that we continue to improve the diet of the tuberculous person rather than relax our standards.

*Do We Feed TB Patients Properly? Horace R. Getz, M.D., The NTA Bulletin, September, 1944.*

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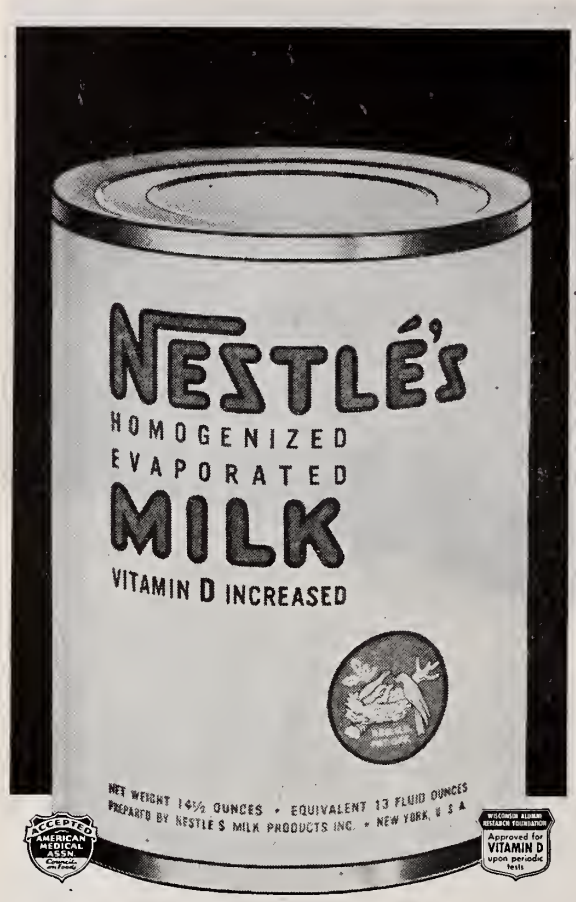
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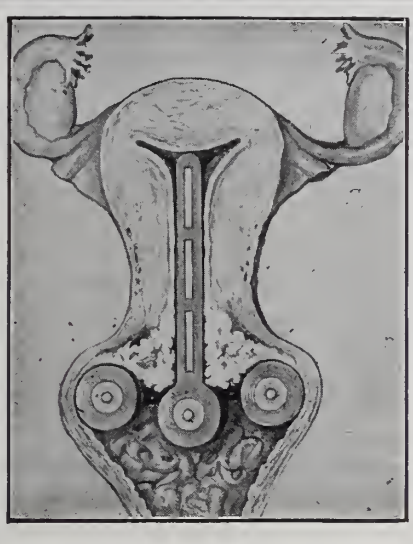
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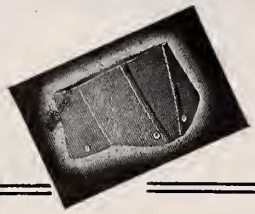
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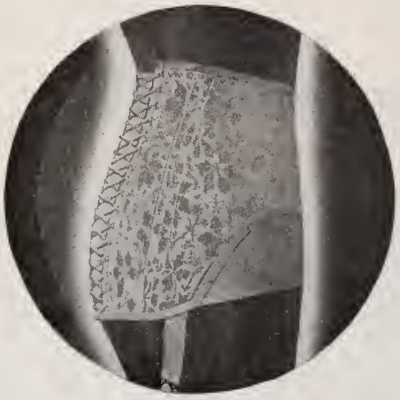
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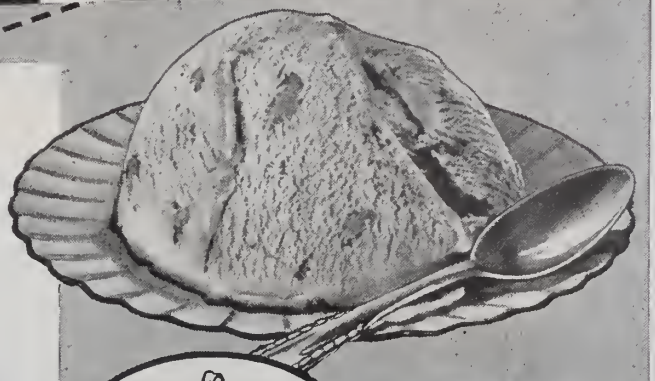
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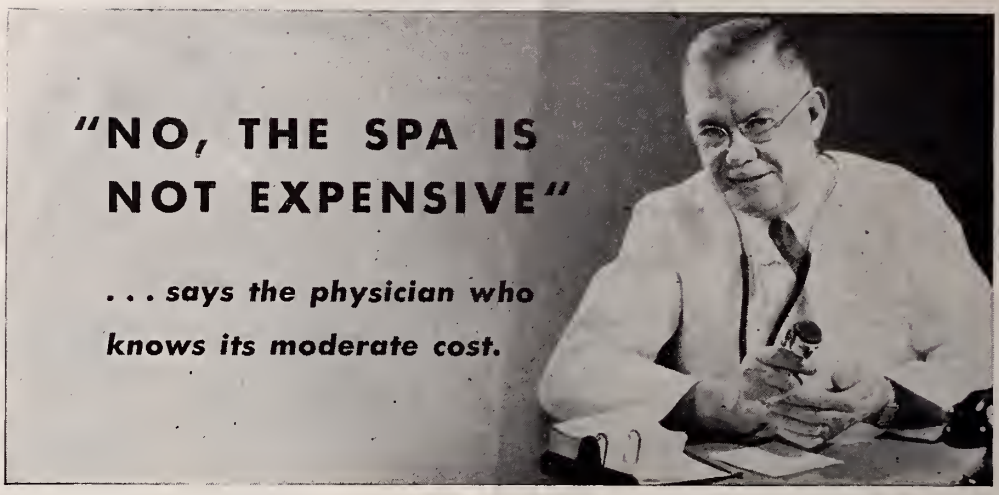
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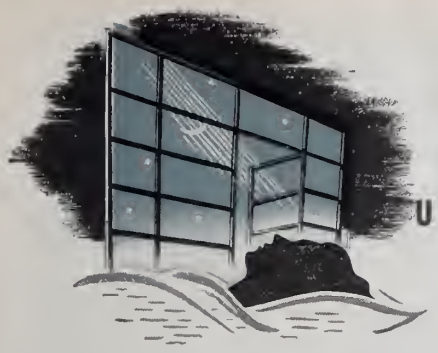
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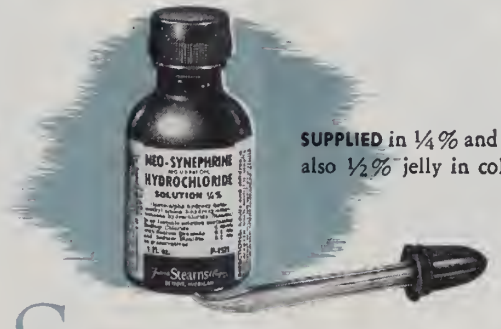
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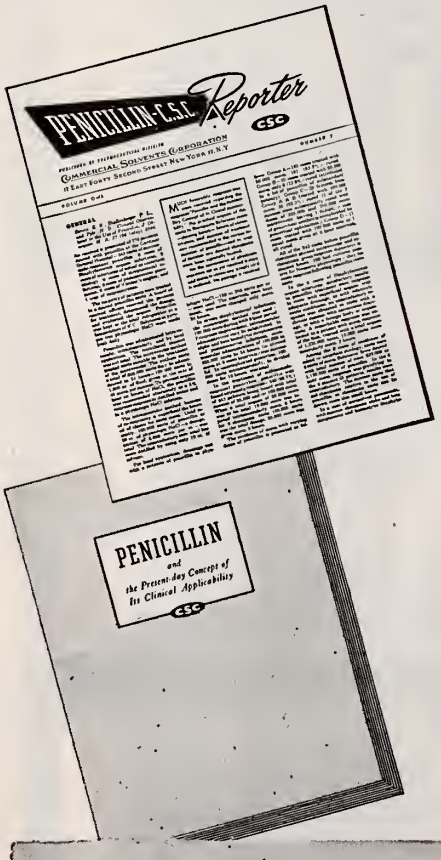
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*Collins, B. C.: Subacute Bacterial Endocarditis Treated with Penicillin, J.A.M.A. 126:233 (Sept. 23) 1944.

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Poindexter, C. A.: The Use of Penicillin in the Treatment of Subacute Bacterial Endocarditis, reproduced by permission of the American Heart Association in J. Arkansas M. Soc. 41:165 (Jan.) 1945.

White, P. D.; Mathews, M. W., and Evans, E.: Notes on the Treatment of Subacute Bacterial Endocarditis Encountered in 88 Cases at the Massachusetts General Hospital During the Six Year Period 1939 to 1944 (Inclusive), Ann. Int. Med. 22:61 (Jan.) 1945.

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**REFERENCES** — 1 West. J. Surg. & Gyn., 51:150, April, 1943. 2 Clin. Med. & Surg., 46:327, August, 1939. 3 Med. Rec., 155: 316, 1942. 4 Crossen, H.S. and R. J.: Diseases of Women, C. V. Mosby Co., St. Louis, 9th ed., 1941.

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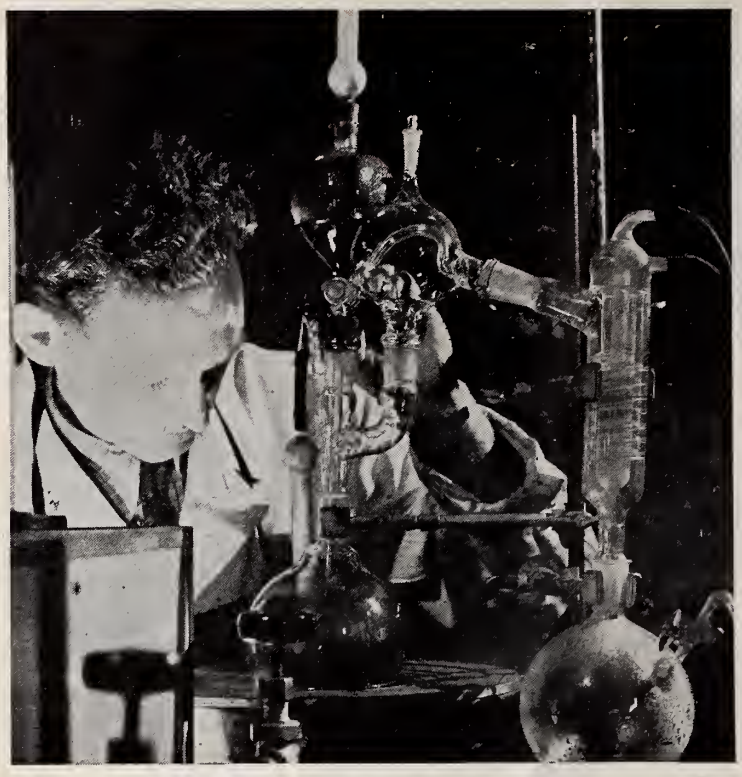
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**1934**—Ascorbic Acid Merck was made available by Merck & Co., Inc.

**1936**—Crystalline Vitamin $B_1$ was synthesized in the Merck Research Laboratories.

**1937**—Vitamin $B_1$ (Thiamine Hydrochloride Merck) was made commercially available.

**1938**—Nicotinic Acid Merck (Niacin) and Nicotinamide Merck (Niacinamide) were made available.

**1938**—Riboflavin Merck was the second pure crystalline vitamin to reach production during that year.

**1938**—Alpha-Tocopherol (Vitamin E) was identified and synthesized by Merck chemists and their collaborators in other laboratories.

**1939**—Crystalline Vitamin $B_6$ was synthesized in the Merck Research Laboratories.

**1940**—Vitamin $B_6$ Hydrochloride Merck (Pyridoxine Hydrochloride) became available.

**1940**—Alpha-Tocopherol Merck (Vitamin E) was made commercially available.

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*Merck & Co., Inc. now manufactures all the vitamins commercially available in pure form, with the exception of vitamins A and D.*



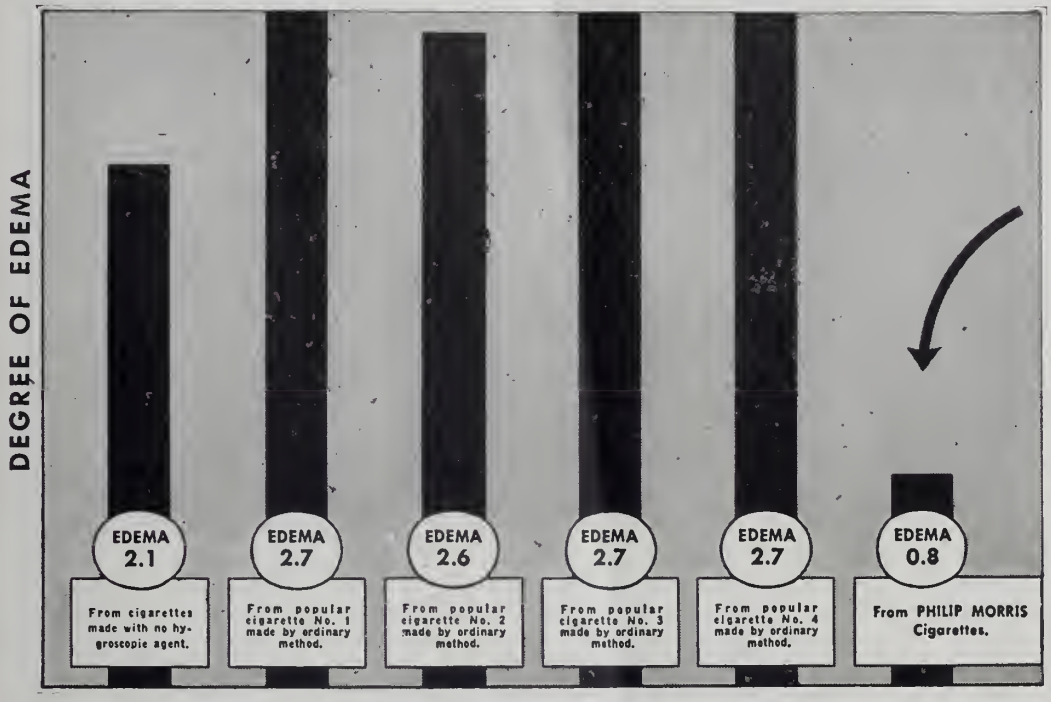

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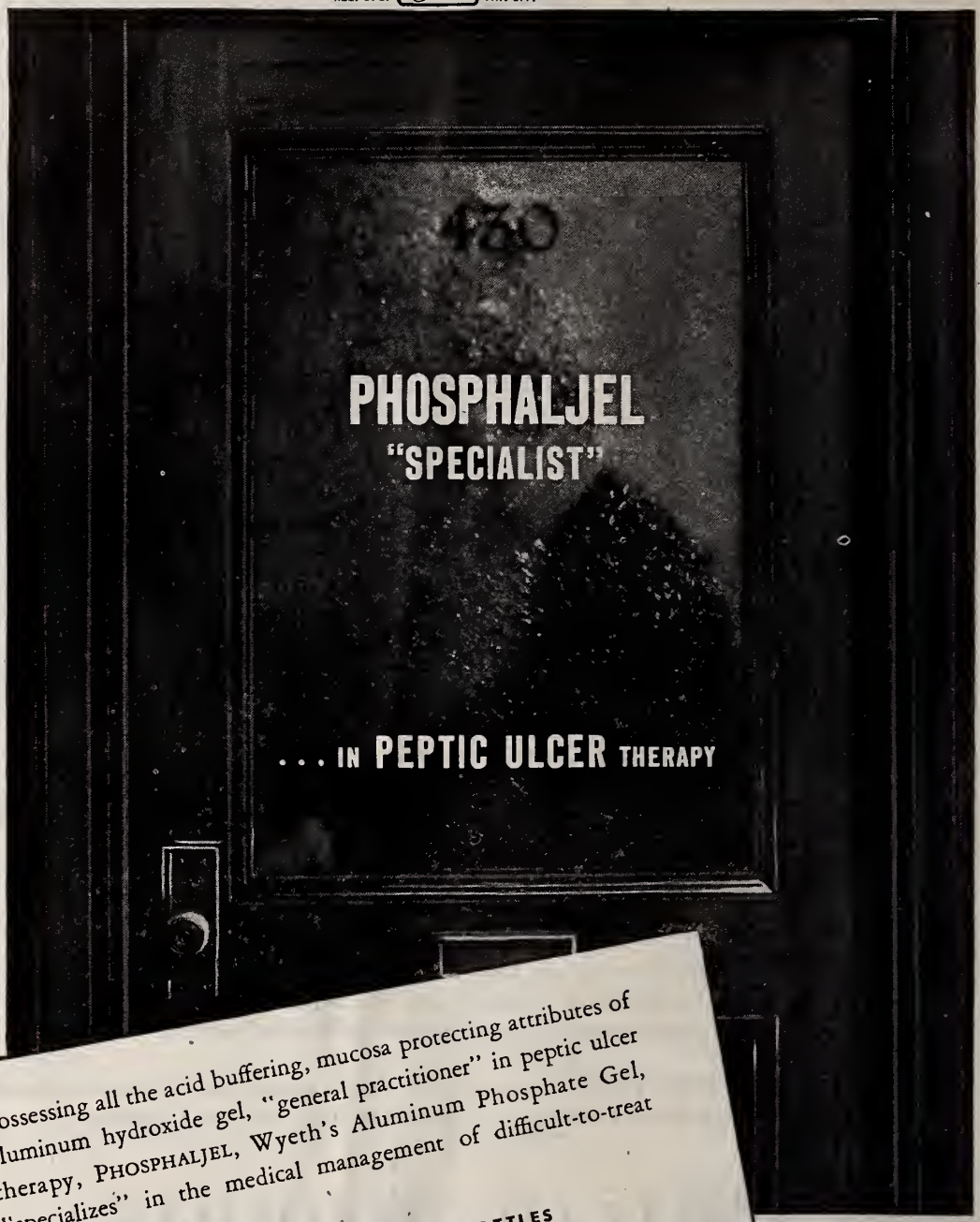
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*N. Y. State Journ. Med. 35 No. 11,590 **Laryngoscope 1935, XLV, No. 2, 149-154

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Myerson, A.—*Anhedonia*—
Am. J. Psychiat., July, 1922.

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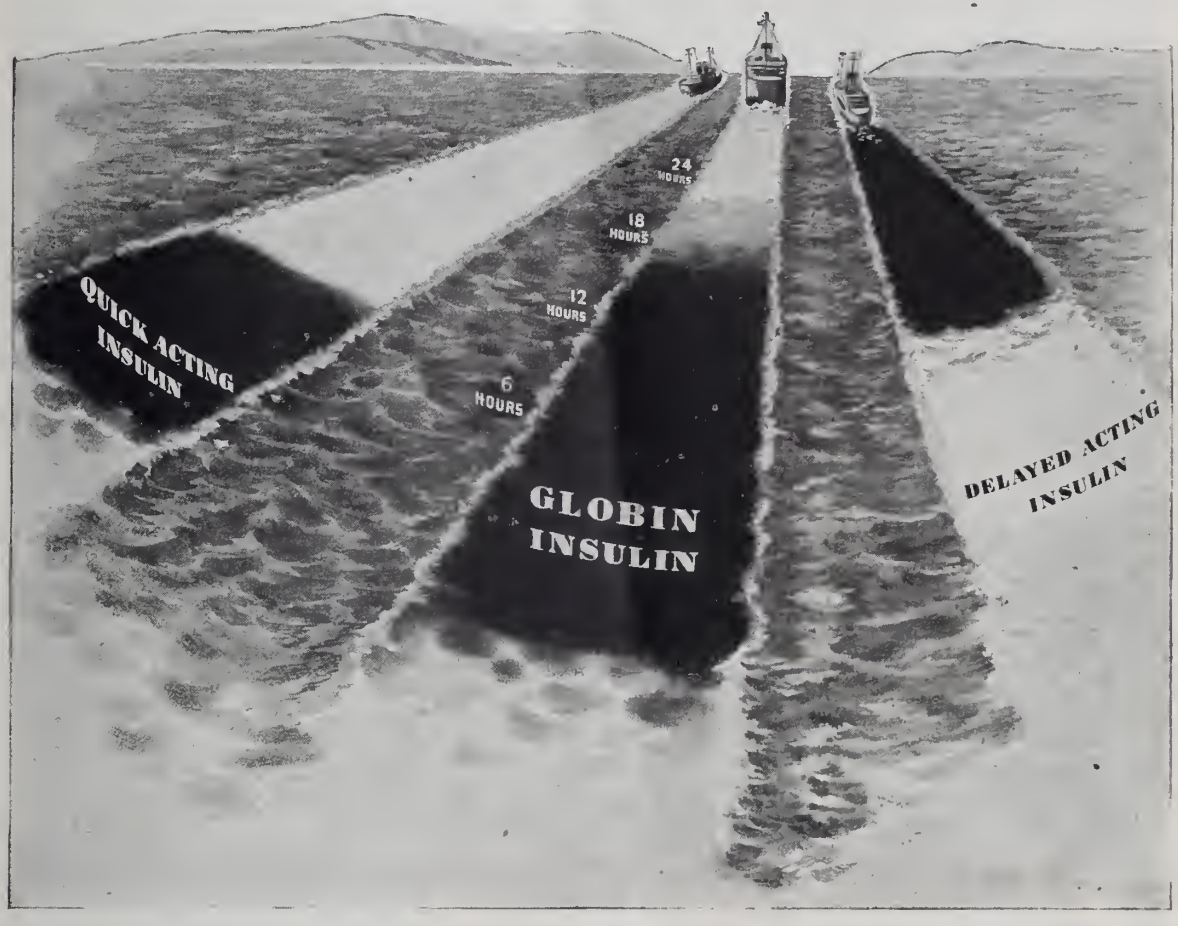
| TYPE OF MILK | NO. OF SAMPLES | | NO. OF COLONIES | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | ON DELIVERY | 1 DAY AT 40°F. | 2 DAYS AT 40°F. | 3 DAYS AT 40°F. | 4 DAYS AT 40°F. | 5 DAYS AT 40°F. |
| Certified-Pasteurized | 22 | Maximum | 20 | 40 | 100 | 850 | 1000 | 1400 |
| | | Minimum | 0 | 4 | 5 | 8 | 15 | 20 |
| | | Average | 8 | 14 | 44 | 157 | 286 | 770 |

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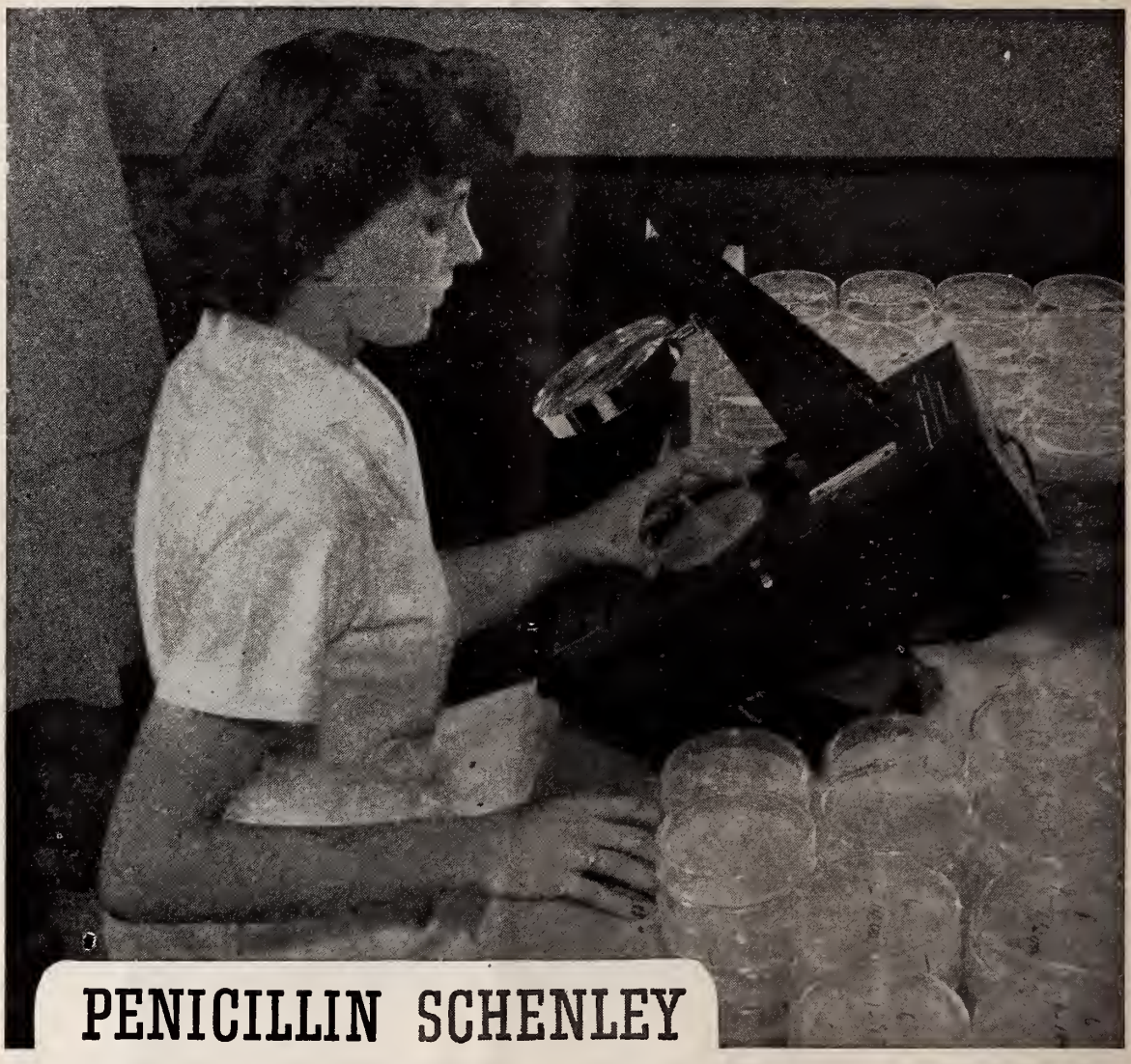
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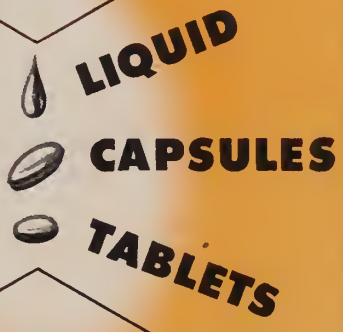



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# EDITORIALS

## PUBLIC RELATIONS AND NATIONAL SICKNESS INSURANCE

More and more people are becoming interested in, and asking more questions about, the medical care distribution problem. It is essential that the individual physician be able to answer their questions intelligently, constructively and without arousing a spirit of antagonism against the opinions of the profession. For this reason *The Journal* will from time to time publish an editorial indicating what it believes to be the proper approach to be assumed by the individual physician. See the February and March issues of *The Journal.*

I. Why can not we have a compulsory sickness insurance system which will be as effective as our present educational system, paid for by taxation? This question is asked frequently, particularly by school teachers. In debating it physicians are embarrassed by being led into a subject with which they are not sufficiently acquainted to warrant debate and it usually results in the physician leaving the false impression that he is opposed to our present educational system.

Advocates of compulsory sickness insurance stress the parallel of compulsory sickness insurance and compulsory education. They are not parallel problems. A common essential education is applicable to all normal children of our general population. Medical care is applicable only to the abnormal or sick individuals of our general population and then only on an individual basis in accordance with the needs of the individual rather than as a common need of the group as a whole.

Our present method of medical care distribution is more efficient and effective than our present educational system as evidenced by the testimony of Dr. John Norton of Columbia University before the "Pepper Committee". Dr. Norton said in part, "We have had to reject 2,000,000 4-F's, enough men to equal the army put on the current Russian offensive, because they were denied educational opportunity." Dr. Norton assailed what he called our "educational slums" and stated that more than half of the

country's school children are given "completely inadequate" schooling. He quoted the 1940 census figures showing that nearly 3,000,000 adults had never attended school, and that more than 10,000,000 persons were illiterate, and that 2,000,000 children between the ages of 6-15 years were not attending any kind of school.

Yes, they are not parallel problems, and any future change in our method of medical care distribution must be more effective than our present educational system if it is to be an improvement over our present system of medical practice.

II. What is medical care? The advocates of compulsory sickness insurance constantly speak in terms of scientific medicine, and insist upon scientific medical care being made available to all of our people. The things they stress are technical in character, such as x-rays, metabolic tests, electrocardiograms and a multitude of laboratory procedures. They fail to appreciate that such services are purely adjuncts to good medical care, applicable only to a minority of sick persons, and that the value of such services are limited by the qualifications of the physician who interprets them. Dr. Frederick Williams of Bronx, New York, expressed it as follows in an address before the New York Board of Trade on November 9, 1944.

"Let me ask you to consider what adequate medical care is. This is a definition I wish someone would make for me. I defy anyone to define adequate medical care to the satisfaction of any community, no matter how large or small, if he is going to do it in terms of science or the accessory services of medical care. But, if we consider medical care as consisting of the personal competence of the physicians in the community, it is not difficult to realize that the services rendered by Dr. Dafoe to the Dionne quintuplets was quite adequate. He did not have all the appurtenances—the nickel-plated machinery — but he did render brilliant care because he was a good doctor. I hope that I have fixed clearly in your minds what constitutes medical care. I will repeat for simplicity and emphasis—medical care consists of the practice of medicine, or the advice of a personal physician to a sick patient. Accessories to medical care are: (1) hospital service; (2) nursing service; (3) technical service; and (4) pharmaceutical service. These accessories are without any value whatever unless they are provided under the intelligent direction of a competent physician."

Medicine has always been and must always be largely an art. If this art is sacrificed or replaced by science through governmental control of medicine, we may no longer have good doctors or good medical care.

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## NEED FOR NURSES

Our wounded are returning home at the rate of over 30,000 per month, crowding all military hospital facilities. The present patient-nurse ratio in our army general hospitals is one nurse to twenty-seven patients. This is a situation which cannot be justified by any alibi. More nurses must be procured if adequate medical care is to be rendered. You as a physician can help if you encourage young nurses to volunteer, if you refuse to employ nurses of military age, if you urge your patients to employ no unnecessary nurses, if you use practical nurses or members of the patient's family as nurses whenever possible and if you explain to your patients that the unwarranted use of nursing service tends to deprive our wounded of the standard of medical care they deserve.

# ORIGINAL ARTICLES

## MENTAL HYGIENE IN NEW JERSEY

### SOME NOTES ON ITS DEVELOPMENT

Emil Frankel
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### FROM INSANE ASYLUMS TO HOSPITALS

The early history of the mental hygiene efforts in New Jersey, as elsewhere, is bound up with the need to provide hospital accommodations for the growing number of insane. Medical treatment in the early days of asylum care reflected the medical practice and philosophy of the era. Growing awareness of the responsibility of the state to attempt vigorously to restore the mental health of patients in mental hospitals caused a change in the names of these institutions from Asylum to Hospital in 1893.

Along with continuous efforts to enlarge the state's hospital facilities for the mentally ill, a measure was enacted authorizing the payment of state subsidies to counties providing for the care of the insane in county hospitals.

All along the New Jersey institutions caring for mental patients have had an honorable record for medical and administrative integrity. This can be attributed to the policies recognized when institutional facilities were first established.

### POLICIES OF THE DEPARTMENT OF INSTITUTIONS AND AGENCIES

In the field of mental hygiene, the State Board of Control of Institutions and Agencies, established in 1918, and the Commissioner of Institutions and Agencies worked closely with the medical directors of the two state hospitals in the effort to develop the institutions to a point where maximum benefits could be obtained for patients and in determining in what way the mental hospitals could aid in an integrated network of welfare facilities.

In 1927, the previously informal conference method was revised and the Board of Control established a "Committee on Mental Hygiene". After control studies of the entire situation, the Committee made a series of recommendations which were accepted by the State Board of Control as a general guide to the supervision of mental hygiene services in New Jersey.

1. Continued transformation of mental hospitals into modern curative institutions.
2. Parole of an even greater number of mental patients by the hospitals under proper supervision and safeguards.
3. Extension of mental hygiene clinics.
4. Development in local general hospitals of psychopathic departments for nervous and mental patients.
5. Education of the general public on the subject of mental hygiene.
6. Research into the causes, treatment, and prevention of mental disease.

### MODERNIZATION OF MENTAL HOSPITALS

The modernization of the state mental hospitals, begun in 1920, was already well under way when the committee submitted its recommendations. Greystone Park, with the receipts of a "half-mill" tax which was provided for the construction and modernization of institutions, was substantially expanded from 1923 to 1927. New buildings were erected at Trenton during this same period. The capacity of the two state hospitals being increased by one-third from 1920 to 1927.

Under the guidance of the Committee on Mental Hygiene, Marlboro State Hospital was designed representing the best modern thought in mental hospital construction. Instead of building a vast congregate structure, a group of unit buildings was designed, each to be used for the care of patients suffering from a particular type of mental disease.

### INTRODUCTION OF NEW MEDICAL TECHNIQUES

The modernization of physical facilities was accompanied by and was intended to facilitate the utilization of new medical techniques. The technique of "insulin shock" therapy, first demonstrated by Sakel in 1933, was introduced in New Jersey State hospitals early in 1937. Metrazol and electric shock therapy have also been utilized. This approach to the treatment of mental disease has yielded results which appear promising, especially in the treatment of dementia praecox. Various other new techniques, including those based upon endocrinology and vitamin control, have received thorough trials.

New Jersey hospitals stress occupational therapy and physical therapy as aids to medical treatment. These programs have involved the use of many different types of activity deemed likely to benefit the patient's physical and mental condition.

### PAROLE OF MENTAL PATIENTS

Efforts to relieve pressure for mental hospital accommodations and to assist patients in returning to community life, through the conditional release and trial visits of patients in the community, were first made at an early stage in mental hospital history.

### PSYCHIATRIC SERVICE IN INSTITUTIONS OTHER THAN HOSPITALS

Another early result of the integration of the mental hospitals with other institutions in a comprehensive welfare department has been the participation of staff members of the mental hospitals in the "classification programs" of penal and correctional institutions.

The "classification program" involves the examination of individuals received at penal and correctional institutions by specialists in a number of fields who pool their opinions and recommend the type of treatment to be followed. The psychiatric service required to operate this plan has been furnished by staff members of mental hospitals.

In 1935, the scope of the "classification program" was extended to permit judges to refer offenders to institutions before the imposition of sentence for "classification, study, and diagnosis".

### MENTAL HYGIENE CLINICS PROGRAM

Extension to the community of facilities for the prevention and early diagnosis of mental disease, through mental hygiene clinics, was a natural development of the programs of the mental hospitals. The development of unified and well coördinated mental hygiene clinic services together with an intensive program of community education in strategic centers throughout the state have been the constant aim of the mental hygiene clinic system based upon the three state mental hospitals.

During the last five years, New Jersey state mental hygiene clinics have cared for more than 3,000 different patients annually. In the course of each year these patients made an average of 4,000 visits.

Clinics were conducted in some 40 different communities in 1943 and nearly 900 clinic sessions were held. In about 30 of these communities regular clinic schedules were maintained for combined psychological and psychiatric services. In communities where attendance warranted clinics were operated on a weekly schedule, while in others bi-weekly or monthly schedules were adopted. In a number of towns where regular clinics could not meet the peculiar needs, special psychological and special psychiatric clinics were held. Many of these special clinics were held in schools or institutions.

### MENTAL HYGIENE ACTIVITIES IN WARTIME

Certain social and economic conditions, which in normal times have deleterious effects upon individuals predisposed to mental disturbances, are accentuated in a war period which is responsible for unprecedented personal and family dislocations.

Mental hygiene in all its various phases thus has had to prepare not only to meet its regular tasks, but in addition to assume new responsibilities imposed upon it by the war. These include:

1. Services for individuals rejected from military service for neuropsychiatric reasons who are experiencing difficulties in making a

satisfactory personal and community adjustment.

2. Services for members of the armed forces discharged for neuropsychiatric reasons, that is, individuals who have suffered mental breakdowns of various severities which will need the application of a variety of rehabilitative measures—psychiatric, occupational, economic, and social.

The rehabilitation of the neuropsychiatric veteran is expected to be primarily the responsibility of the Federal Government. Increased hospital facilities will be provided for the veterans of the present war with service-connected mental illness.

It is clearly evident, however, that the provision of additional hospital facilities is only a partial answer. In addition to those requiring hospitalization many more men and women discharged from the armed forces for neuropsychiatric reasons will present problems not requiring hospital care, but will require mental hygiene services in their respective communities.

The State Rehabilitation Commission, heretofore primarily concerned with physical rehabilitation, is authorized to render aid to the psychiatrically disabled civilians and veterans under new Federal legislation.

### COMMUNITY MENTAL HYGIENE SERVICES

While the state has given general direction to the mental hygiene movement it is important that the counties and communities themselves fully appreciate the need of appropriate mental hygiene facilities and make every effort to tie together effectively existing efforts.

In *Essex County* a variety of mental hygiene activities have been developed. These include: county mental hospital and mental hygiene clinic services conducted under its auspices; the Essex County Juvenile Clinic attached to the Juvenile Court; the psychiatric services of the County Probation Department and the psychiatric clinic service of the Newark City Board of Education. There is also mental hygiene clinic service available in several general hospitals.

*Union County* has recently established a county-wide mental hygiene organization.

### GENERAL MENTAL HYGIENE PROGRAM

Now and in the days to come conscious efforts will have to be made to spread the knowledge of the principles of mental hygiene as a program to foster and maintain sound mental health among all the people.

In the community as a whole we must develop appreciation of the importance of early recognition in nervous and mental disorders and the importance of correcting minor mental disturbances which may be contributory factors to more serious ailments in the future; and the development of means by which all persons who show signs of mental disturbances, however slight, may be assured of early attention and appropriate treatment.

### OUTSTANDING ACTIVITIES IN MENTAL HYGIENE PROGRAM

Among the outstanding activities in the field of the control and prevention of mental disturbances and the preservation of mental health may be listed the following together with the state organizations which might guide them:

*State Department of Health* in conjunction with local health departments to develop instructions regarding both the physical and mental health of children and to supplement the service and advice of the family doctor.

*State Department of Education* and local education departments to stimulate interest and activities for more adequate provision for individual needs and the early recognition and treatment of maladjustments in the pupil's mental and emotional life.

*State Department of Institutions and Agencies* in coöperation with local authorities to develop and extend its program for the operation of existing mental hospitals as modern treatment and curative institutions; extend the system of mental hygiene clinics based on the mental hospitals to serve the communities in the diagnosis of mental and nervous disorders, and to reach potential sufferers from nervous or mental disorders before the definite breakdown occurs; and encourage local general hospitals to develop psychiatric departments for the milder mental cases.

*Medical Society of New Jersey* and com-

ponent county medical societies to develop measures looking toward the more general development among practicing physicians of a keener appreciation of the importance of mental and emotional influences in ordinary illness.

*The New Jersey Mental Hygiene Association* has carried on a program designed to promote an understanding of the mental hygiene movement. In recent years it has been especially active in developing mental hygiene programs pertaining closely to the work of the public schools.

### NEED FOR INTEGRATION OF MENTAL HYGIENE ACTIVITIES

New Jersey has many organizations—public and private—which are ready to enlarge their services and facilities to meet the mental hygiene needs of the day. It is important that these organizations study their resources and possibilities so as to gain a thorough understanding of what service each is capable of rendering and how their forces may be dovetailed with each other to render the most effective service.

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## PROPOSES SUPPORT OF HILL-BURTON HOSPITAL CONSTRUCTION BILL

Pointing out that the Board of Trustees of the American Medical Association have indicated that the general policies of the Hill-Burton Hospital Construction Bill now before Congress should receive the support of the medical profession, *The Journal of the American Medical Association* in an editorial in its March 17 issue warns that the accomplishments sought by the measure can come only when construction of facilities depends on evidence of ability to maintain the proposed institution and to provide competent personnel. Discussing a recent hearing on the bill held by the Senate Committee on Education and Labor, *The Journal* says:

"The Board of Trustees of the American Medical Association at a recent meeting indicated that the general policies of this measure are within the platform of the American Medical Association and expressed the opinion that the bill should receive the support of the medical profession.

"As was pointed out by Dr. R. L. Sensenich (Trustee of the Association), this measure embraces the principle that the need for an institution is to be established by adequate evidence before funds are allotted for its construction. The Hill-Burton measure recognizes that conditions vary as regards health in different parts of the United States. Obviously the success of this measure, if it becomes effective, will depend largely on the constitution of the Federal Advisory Council, which will have more authority than has generally been granted to such advisory groups in relation to federal agencies. Several suggestions were made by Dr. Sensenich tending toward strengthening of the responsibilities of this council.

"As Dr. Sensenich pointed out also the term 'public health center' has never been clearly defined. Such an agency might under present definitions undertake a number of functions quite outside the scope of either preventive medicine or the extension of medical service where needed. In certain areas of this country a public health center might be required to undertake procedures which would not be considered either desirable or necessary in other areas.

"In his testimony on the Hill-Burton measure Dr. Victor Johnson (Secretary of the Council on Medical Education and Hospitals of the American Medical Association) supplemented the statement of Dr. Sensenich. He emphasized the desirability that a Federal Advisory Council, dealing with the construction of hospitals and health centers, include men of experience in the fields concerned; because of such experience they could command the full support of hospital administrators, physicians and the public.

"Dr. Johnson took advantage of the occasion to emphasize again the great importance of legislation which would guarantee for the postwar period adequate numbers of premedical and medical students.

"A medical service is no better than the quality of the physicians who render the service. The mere construction of facilities is not in itself any guaranty to an area that it will have sufficient medical care of high quality. Complete effectiveness in achieving the objective that the proponents of the Hill-Burton measure desire to achieve can come only when construction of facilities is dependent on evidence of ability to maintain the institution and to provide competent personnel."

# RESPIRATORY DISEASES IN THE TROPICS *

LT. COL. IRVING L. APPLEBAUM, M.C., Newark, N. J.

Respiratory diseases in the tropics present all the problems which confront the physician in the Temperate Zone but, in addition, there are phases peculiar to the Torrid Zone. The occurrence of respiratory diseases varies in different tropical locales, depending upon the incidence of certain etiological factors, the hygienic standards and, to a lesser extent, upon the character of the climate, particularly in relationship to humidity and extremes of heat. The concepts of this presentation are based upon experience (1942-1944) in a zone (Panama Canal), where the Health Department has done splendid public health work in elevating the hygienic status, employing prophylactic measures and isolating active cases. Therefore, it can be assumed that a more favorable level of health than in similar geographical sites is attained in this area.

The weather is usually warm though tolerable throughout the year, which is made up of two seasons, the "dry" (January through April) and the "rainy" (May through December). During the "rainy" season, however, the humidity is higher and at times causes considerable discomfort. The following table, prepared by Crum,[1] presents climatic data for seasonal averages in this zone:

| | Dry Season | Rainy Season |
|---|---|---|
| Rainfall, inches | 5.2 | 65.1 |
| Wind, average velocity m.p.h. | 9.5 | 5.9 |
| Temperature, bihourly mean | 79.2 | 78.4 |
| Temperature, daily range | 17.2 | 12.8 |
| Humidity, per cent | 76.0 | 86.5 |
| Sunshine, hours per day | 8.2 | 5.1 |
| Cloudiness, per cent | 52.0 | 75.0 |
| Pressure, inches | 29.84 | 29.82 |

## ALLERGY

Allergy, manifested by respiratory symptoms, is fairly common in Panama and offers an opportunity for new investigations. In 1942 approximately 942 patients were examined and treated by the Allergy Department of Gorgas Hospital, and in 1943 there were 422 cases on the active file.[2] The flora in the Panama Canal Zone were studied and approximately 2,000 species of flowering plants were listed. This impressive figure offers an index to the wide scope of possibilities and the difficulties involved in specific sensitivity tests. Inhalant allergic problems are essentially perennial, although there is some seasonal variation. Heavy pollens are of relatively greater importance here because of closer contact with sources and strong trade winds. Some 150 poisonous or injurious plants in Panama have been described by Allen.[3] Many, as the manzanillo (beach apple) and mango, are responsible for contact dermatitis. The palms, especially the royal palms, produce abundant pollen, to which sensitive individuals react. Mixed grass pollenosis is also fairly common and jungle exposures of military personnel increase the problems. Then there is the abundant rainfall of the "wet" season, which is conducive to the growth of moulds, adding quantitatively and qualitatively to the causative agents. Allergic manifestations seem to occur with about equal frequency in such different racial groups as white Americans, native Panamanians, West Indian Negroes and citizens of other Latin-American countries. It has been observed that American patients who present a previous history of bronchial asthma in the United States often become worse in this zone. This is explained on the basis of humidity and the superimposition of new allergens, native to this area.

## UPPER RESPIRATORY DISEASES

Infections of the nose, pharynx, ears, sinuses, tonsils and larynx are similar in nature to those found in the United States. However, they seem to undergo a more benign course and, although scientific confirmation is lacking, extensive clinical experience indicates that the

* From the Medical Service of Gorgas Hospital, Ancon, Canal Zone.

1. From the Section of Meteorology and Hydrography, The Panama Canal; Climatic Data prepared by Charles F. Crum, 1941.

2. Personal communication with Major N. M. Newport, M.C., Chief of Allergy Division, Gorgas Hospital, Canal Zone.

3. Allen, P. H.: Poisonous and Injurious Plants of Panama. Am. J. Trop. Med. (suppl.), 23:1-76, 1943.

respiratory bacteria are less virulent. This is particularly true of the various strains of streptococci,[4] which apparently induce milder syndromes not only in respiratory diseases but also in such streptococcal diseases as erysipelas, nephritis, scarlet fever, etc. Lepromatous involvement of the nose and occasionally of the larynx is seen in patients of the leper colony in this area. Mycological infections of the external auditory canal are relatively more common than in colder climates. Cases of acute laryngo-tracheo-bronchitis, particularly in children, have been severe enough to indicate surgical intervention by tracheotomy. Bronchitis, subacute or chronic, often runs a prolonged course and, when it is infectious rather than allergic, favorable response to sulfa nebulization[5] is noted.

### ACUTE PULMONARY LESIONS

During a 14-month period (1942-1943) a study was made of 500 consecutive cases of primary pneumonia,[6] in which the lesions were chiefly lobular in character and the average course was benign. There were only seven deaths (0.7 per cent mortality rate) in the entire series. Most of the cases closely resembled the disease known as "atypical pneumonia", but virus facilities were not available for a thorough classification. In about one-fourth of this group, bacteria as pneumococci, diverse strains of streptococci, staphylococci, etc., were the etiological agents. The percentage of severe pneumonias in the black population was higher than in white Americans. Pneumonia has been a tropical problem ever since invasion by the white man and, during epidemics, the mortality rate in the native population has been appalling. With the advent of sulfa chemotherapy, better control and improved living conditions, the survival rate has been markedly improved.

From a viewpoint of differential diagnosis, special consideration must be given to the possibility of secondary involvement. The pulmonary process may be part of a protozoal disease and such lesions have been described in kala-azar, and amebiasis. Pneumonia also has occurred in such metazoal diseases as ascariasis, Strongyloides infestation, ankylostomiasis and fluke infections. In cases of heat pyrexia when pulmonary congestion is present, pneumonia occasionally may be a sequela.

### CHRONIC PULMONARY LESIONS

*Tuberculosis.*

The susceptibility of the black and yellow races to the scourge appears to be accentuated in tropical belts. Natives of sea-level regions suffer more than those of mountain plateaus and, similarly, those in areas of high humidity fare worse than people in arid sections. Tuberculosis is an important cause of death in the Philippine Islands, the East Indies, other Pacific zones, the West Indies, portions of Africa and the Far East. Robert Louis Stevenson vividly described the rapidity of its spread and the malignancy of its course in the Marquesan Islands. In the Panama area the disease is more severe among the blacks and natives than it is in white Americans. While hygienic, social, and economic factors are more important than climate, it is appreciated that a complete rest cure is made more difficult by the discomfort of humidity. For this reason, it has been the policy of the Health Department of the Panama Canal to transfer United States citizens to their homeland.

However, a certain proportion of white Americans and most natives have been treated here by universally recognized methods. Under proper supervision and the employment of the various forms of collapse therapy, satisfactory results have been attained. Although enervation caused by climate has been recognized as a handicap, it is by no means an overwhelming factor.

*Mycoses.*

The incidence of pulmonary mycoses has been relatively low as compared with the abundant growth of moulds in this zone. Perhaps it is accountable by the low pathogenicity of the organisms. All pulmonary cases at Gorgas

4. Personal communication with Lt. Col. L. B. Bates, M.C., Director of the Health Department Laboratory, Panama Canal.
5. Applebaum, I. L.: The treatment of bronchial lesions by the inhalation of nebulized solution of sodium sulfathiazole. Am. J. Chest Dis., Sept. 1944.
6. Applebaum, I. L., and Shrager, J.: The Pneumonias in Panama. Accepted for publication by Am. J. Tropical Dis.

Hospital undergo intensive studies for fungi and sputum is routinely implanted upon Sabaroud's medium. Cases of moniliasis, coccidiomycosis and blastomycosis have been detected, but they have been few in number.

*Miscellaneous.*

Most of the chronic pulmonary conditions, such as carcinoma, lymphoblastomas, bronchiectasis, lung abscess, mediastinal tumors, sarcoidosis, silicosis and emphysema are seen in this zone. The incidence of carcinoma of the bronchus is minimal, but this is more apparent than real, and can be explained by the high percentage of lower age groups (military personnel and civilian employees). There is no particular problem of location or environment.

SUMMARY

1. Respiratory diseases in the tropics present all the problems confronting the physician in the Temperate Zone.

2. In addition, there are etiological factors, native to warmer climates. Therefore special studies are necessary, particularly in search for protozoal and metazoal agents.

3. Although climate plays a fractional rôle in influencing the treatment and course of respiratory diseases, it seems less important than social, economic and hygienic standards.

*Acknowledgment.* Gratitude is expressed to Estelle Hall, Medical Secretary in the Health Department, for her aid in the preparation of this manuscript.

## NECROPSIES IN INTERNSHIP HOSPITALS

Under wartime conditions, with staff shortages, efforts at maintaining an adequate necropsy percentage tend to lag in some hospitals. The Council on Medical Education and Hospitals is aware of these difficulties, yet its responsibility for maintaining educational standards remains. The Council cannot continue for approval hospitals which fail to maintain the required 15 per cent of necropsies or which are unable to correct deficiencies in necropsy performance within a reasonable time. The necropsy ratio of a hospital is recognized as one of the more reliable indexes of the quality of educational service in hospitals. This service is especially important now, since the curtailed internships must be made maximally valuable to house officers. To insure that postmortem examinations are requested on all deaths, house officers should be required in each instance to file a report in the superintendent's office containing either a signed permit or a notation as to why the necropsy could not be obtained. This procedure has been extremely helpful in many hospitals, for it creates further interest among the medical staff and serves to stimulate the interns and residents to greater effort. — Current Comment, J. A. M. A., Vol. 125, No. 6, p. 1145.

## EXHAUSTION SYNDROME

A syndrome not found described in the literature has been observed—neuromuscular exhaustion followed by atrophy and fascicular twitching requiring months for recovery. During a period of euphoria with oblivion of fatigue a person continues to work until he suddenly realizes complete neuromuscular exhaustion approaching paralysis. Psychomotor restlessness continues, pains and tenderness are prominent, the muscles become flabby while they twitch and atrophy; paralysis supervenes with great loss of body weight. Months are required for recovery. In most severe cases residuals remain; exacerbation may appear after relatively slight exertion. The patients are not neurasthenic; they rather ignore their disability and herein lurks danger. — Nielsen, J. A. M. A., Vol. 126, No. 13, p. 801.

# STATE ACTIVITIES

## RUSSIAN WAR RELIEF

The Essex County Russian War Relief announces the organization of a Medical Text Book Committee to solicit books for shipment to the colleges and universities in the Soviet Union. Dr. Max Danzis is Chairman. Serving on the committee with him are Dr. Royal A. Schaaf, Dr. Henry C. Barkhorn, Dr. Aaron E. Parsonnet and Dr. Herbert A. Schulte.

There is urgent need for these books because so few are now available for the all important training of doctors and nurses. The invading Nazi armies burned all they could seize and there has been almost no publication since the war began. What remains is worn out by use.

Over three years of total war has placed on the medical profession the superhuman task of caring for the millions of wounded and sick. Each new victory increases the demand. New personnel has to be trained and text books are needed for this purpose.

Any medical text books published *subsequent to 1926* and written in English, French, German or Russian, or classics of *any date* are most welcome. Donations may be made personal by pasting a greeting label inside the books. Labels may be secured from the RWR Headquarters, 744 Broad Street, Newark, where books should be delivered.

## STATE OF NEW JERSEY DEPARTMENT OF HEALTH

### PENICILLIN TREATMENT FOR SYPHILIS AND GONORRHEA

The New Jersey State Department of Health provides penicillin and/or hospitalization for the following types of patients:

1. Primary syphilis (chancre).
2. Secondary syphilis (rash, mucous patches, condyloma, etc.).
3. Latent syphilis *definitely* of less than one year duration.
4. Congenital syphilis under one year of age.
5. Gonorrhea in patients who either
   a. Are resistant to at least 20 grams of sulfonamide, or
   b. Are intolerant to sulfonamides, or
   c. Have serious, acute complications of the disease (epididymitis, ophthalmia, acute salpingitis, acute arthritis).

Penicillin is also provided for ambulatory treatment of the above types of gonorrhea in clinics and physicians' offices.

Certification must be made that the patient either:

1. Cannot afford to pay, or
2. Is under isolation imposed by the health officer under authority of law.

Application blanks and recommended schedules of treatment are available at most hospitals or from the State Health Department, Trenton. If difficulty is encountered in arranging for a hospital bed, the attending physician may either write to this Department or phone (Trenton 2-2131, Extension 704) for assistance.

Some patients may refuse treatment in a hospital near home because of fear that friends who are employees of the hospital will learn of their venereal infections. Such patients may be hospitalized in other cities where they are not known.

Penicillin treatment has a profound immediate effect upon syphilitic lesions and is effective in controlling infectiousness. However, this therapy, like all other rapid forms of treatment, interferes with the development of natural immunity. Thus, whereas reinfections after "standard" (arsenic-bismuth) treatment are infrequent, with penicillin treatment reinfections are relatively frequent unless the source of infection and exposed persons are found and treated. (With gonorrhea, reinfection has always been a problem.) Therefore, with penicillin treatment contact investigation is doubly important. Physicians are urged to arrange for *all* of their venereal disease patients (regardless of income, social standing, race or sex) to be interviewed for contacts by skilled investigators, specially trained and ex-

perienced in this work. These investigators are also trained and instructed in the protection of physician-patient relationship. For information as to the availability of this service in your local community write to your State Health Department. If, after using this service, you have any complaints or constructive suggestions, please tell us about them. Only in this way can a satisfactory coöperative relationship between physician and health department be maintained for the effective protection of the public health.

## WITH NEW JERSEY MEDICAL AUTHORS

Compiled by MILDRED V. NAYLOR, Librarian, Academy of Medicine of Northern New Jersey

It is requested that any New Jersey physician who publishes an article outside the state, notify the Editorial Office in Trenton, giving the title of the paper and the name of the periodical, as well as the month, date, volume and page number. It would also be helpful to this office if members would notify us of articles published by their colleagues.

ALLEN, M. J.—Statistician, Standard Oil Co. of N. J.
Medical statistics for 1943. Indus. Med. 14: 98, Feb. '45

APPLEBAUM, I. L.—Newark (in service)
1. Treatment of bronchial lesions by the inhalation of nebulized solution of sodium sulfathiazole. Dis. Chest 10: 415, Sept. '44
2. Cerebrovascular accidents following epinephrine injections. J. Allergy 15: 392-394, Nov. '44

BAKER, ELSWORTH F.—Marlboro
Brief psychotherapy; report of a case. J. Med. Soc. New Jersey 42: 46-48, Feb. '45

BONNET, W. LAURENCE—Mercerville (in service)
New x-ray devices. Air Surgeon's Bull., Jan. '45

GOREN, SIDNEY, B.A.—Applied Research Laboratory, Dayton (in service), with others
Silicosis, in foundries of naval gun factory. U. S. Nav. M. Bull. 44: 653-660, Mar. '45

GORENBERG, HAROLD—Jersey City (in service) with Philip Shulman
Sulfonamide therapy in gonorrhea. U. S. Nav. M. Bull. 44: 596-598, Mar. '45

JUDGE, JOHN F.—Newark
Penicillin sodium in the treatment of sulfonamide-resistant gonorrhea. J. Med. Soc. New Jersey 42: 45, Feb. '45

KLINE, ORAM R.—Camden
Importance of pathologic conditions of the nasopharynx to the otolaryngologist. Arch. Otolaryng. 41: 140-142, Feb. '45

KORNFELD, WERNER — East Orange, with Edmund Nobel, London
Evaluation of nutritional state in children. The Lancet, p. 543, Oct. 21, '44

NAYLOR, MILDRED V.—Newark
A New Jersey petition. Bull. Hist. Med. 17: 93-100, Jan. '45

PARSONNET, EUGENE V.—Newark (in service)
Repair of direct hernia. U. S. Nav. M. Bull. 44: 507-508, Mar. '45

SATULSKY, EMANUEL M.—Elizabeth (in service)
Purpura annularis telengiectodes (with report of an early case). J. Med. Soc. New Jersey 42: 42-44, Feb. '45

## OBITUARIES

### DR. FRANCIS A. DONLAN

Dr. Francis A. Donlan, a resident of Metuchen for almost 18 years, died on February 6, 1945, at St. Peter's Hospital, New Brunswick.

Born in Shamokin, Pa., in 1887, Dr. Donlan acquired his academic and pre-medical training at Manhattan College, New York. A graduate of the University of Pennsylvania Medical School in 1912, he interned at St. Joseph's Hospital, Philadelphia, and the Norristown State Hospital.

Dr. Donlan practiced in Cambria County, Pa., until 1928, when he moved to Metuchen. In addition to his general practice, he was affiliated with the local Sanitary Department, District Departments of Schools and Hygiene and the Public Health Control Department of Labor Industrial Hygiene. He also served as Chairman of the Middlesex County Committee for the Chronically Ill.

Dr. Donlan was a member of the Middlesex County Medical Society, The Medical Society of New Jersey and the American Medical Association.

### DR. EUGENE W. ERLER

Dr. Eugene W. Erler of South Orange died of a heart attack on March 17, 1945, whlie playing golf.

Dr. Erler was born in Newark in 1882, and was graduated from the College of Physicians and Surgeons of Columbia University in 1907.

Dr. Erler was on the staffs of Newark Presbyterian, East Orange General and Orange Memorial Hospitals, and was a member of the Essex County Medical Society, The Medical Society of New Jersey, the American Medical Association and the Academy of Medicine of Northern New Jersey.

### DR. WILLIAM F. KEIM

Dr. William F. Keim, who had practiced medicine in Newark for 40 years, died on March 7, 1945, at the age of 76.

Dr. Keim was born in Addison, Pa., on August 2, 1868. He was graduated from Western Normal College of Shenandoah, Iowa, and taught English and allied subjects in the Middle West. He was headmaster of a private academy when he decided to study medicine. He was graduated from the University of Pennsylvania in 1899 and served his internship at Newark City Hospital. He practiced in the Roseville section, first as a general practitioner and later as an ear, nose and throat specialist.

Dr. Keim was chief of rhino-laryngology at St. Michael's Hospital and chief of oto-laryngology of Newark Memorial Hospital and the Hospital of St. Barnabas and for Women and Children. He was a member of the adjunct staff of St. Barnabas and Presbyterian hospitals.

Dr. Keim was a member of the American Academy of Ophthalmology and Oto-Laryngology, Academy of Medicine of Northern New Jersey, Essex County Medical Society, The Medical Society of New Jersey and the American Medical Association.

### DR. HILDA KINKEAD

Dr. Hilda Kinkead of Madison died suddenly on March 19, 1945, in Morristown Memorial Hospital.

Dr. Kinkead, who was born in 1910, was a graduate of New Jersey College for Women and the Women's Medical College of Pennsylvania. She served her internship at Jersey City Medical Center and was house doctor at Overlook Hospital, Summit, before entering practice in Madison. She also served as resident physician at the New York Infirmary for Women and Children.

Dr. Kinkead was on the staff at Overlook Hospital and two years ago took over the practice of Dr. Theodore Failmezger when he entered the Army.

Dr. Kinkead was a member of the Morris County Medical Society, The Medical Society of New Jersey and the American Medical Association.

### DR. ERVIN McELROY

Dr. Ervin McElroy, a practicing physician in Rockaway for 21 years, died at his home from a heart attack.

Dr. McElroy was born in Landing on October 11, 1896. He attended Syracuse University and was graduated from the Jefferson College of Medicine in 1922. He served his internship at the Newark City Hospital and started to practice in Rockaway in 1924.

Dr. McElroy was a member of the Morris County Medical Society, The Medical Society of New Jersey and the American Medical Association.

### DR. JOHN T. ROBINSON

Dr. John T. Robinson, former Bound Brook mayor, and a practicing physician nearly 50 years, died at his home in Bound Brook after a long illness.

Dr. Robinson was born in Philadelphia in 1865, and was graduated from Hahnemann Medical College in 1896. He was on the staff of Muhlenberg Hospital and was a member of the Somerset County Medical Society, The Medical Society of New Jersey and the American Medical Association.

## KILLED IN ACTION

### CAPTAIN ORRIN F. CRANKSHAW

Captain Orrin F. Crankshaw of Wyckoff, who was awarded the Bronze Star and the Purple Heart recently for treating injured soldiers under heavy enemy fire when wounded himself, was killed in action in Germany on February 23, 1945, at the age of 35.

Captain Crankshaw was graduated from Cornell University Medical School in 1935, and until entering service in June, 1942, instructed in medicine at Yale Medical School. He went overseas with the Yale Medical Unit and participated in the operations at Guadalcanal. After returning to this country with malaria, he was sent to England in February, 1944.

In January of this year, Captain Crankshaw was awarded the Bronze Star for meritorious achievement in France between July 28 and October 10, 1944, when he operated with an advance guard, many times traveling in an open vehicle and treating wounded men under fire. On one of these occasions his vehicle struck a mine and he was thrown to the ground. But in spite of a ruptured ear drum and other injuries he continued his work.

Prior to entering the service, Captain Crankshaw practiced medicine in Summit. He was also on the staff of Overlook Hospital and was attending physician at the Bell Telephone Laboratories at Murray Hill. He was a member of the Union County Medical Society, The Medical Society of New Jersey and the American Medical Association.

# COUNTY SOCIETY REPORTS

## ATLANTIC COUNTY

Walter B. Stewart, M.D., Reporter

The regular monthly meeting of the *Atlantic County Medical Society* was held Friday, March 9, 1945, at the Hotel Chelsea, with the President, DR. CHARLES HYMAN, presiding.

The speaker of the evening was DR. DAVID A. COOPER, Assistant Professor of Medicine, University of Pennsylvania Graduate School of Medicine, whose subject was "Chemotherapy of Tuberculosis". Attempts to treat tuberculosis with gold compounds or with tuberculin have been unsuccessful. More recently sulfanilamide was thought to have an inhibiting effect on the growth of tubercle bacilli in vitro and in guinea pigs. It has been observed that large amounts of sulfanilamide can be used in treating human tuberculosis with no beneficial results, but also with very slight toxic effect. Diamino-diphenyl-sulfone has been used experimentally and found to be bacteriostatic for tubercle bacilli. One of the sulfones, promin, has caused resolution of tuberculous lesions in the liver and other organs of guinea pigs. Promin is capable of exerting a definite therapeutic influence on tuberculous lesions. However, in a study of a group of patients for three months, toxic effects were observed in all cases, and few beneficial results were found. Among the toxic manifestations were anemia, cyanosis, leucopenia, dermatitis, fever and gastro-intestinal symptoms. Promin is more toxic when given orally than parenterally. Locally it has been found to heal tuberculous ulcers in animals. Nebulization may cause few toxic effects and good therapeutic results in bronchial ulceration.

Another sulfone, diasone, has inhibited growth of tubercle bacilli in guinea pigs. One series of forty-four patients with pulmonary tuberculosis were treated with this drug, 0.33 gms. t.i.d., with an average blood level of 0.8-1.5 mgms.%. There were no severe toxic effects after 120 days of treatment, except the development of slight to moderate anemia. Clinical improvement occurred at first in most cases, but later results were not so good. Other workers have reported excessive toxicity. Promizole has also been tried but is toxic and gave little clinical improvement in pulmonary tuberculosis.

The most likely explanation of the retarding effect of the sulfones on the tubercle bacilli, as of sulfonamide, is in the general or organic anoxia and the cyanotic effect on the internal organs. Diazone has been used clinically in daily oral dosage of one gram for months with no definite anoxemia; hence it is doubtful if a therapeutic effect is obtainable in man. It does not seem warranted to continue these human experiments at present.

Dr. Cooper stated that promin is more toxic than diazone. However, he has used promin intrathecally in a patient with tuberculous meningitis with control of symptoms but ultimate death of the patient. A patient with tuberculous pericarditis also showed definite improvement. Recent consensus is that promin, though toxic, does have beneficial effect on human tuberculosis, but that diazone and the sulfonamides do not.

Among the antibiotics, streptomycin has been found bacteriostatic and bacteriocidal to human tubercle bacilli. It has low toxicity in animals, and was well tolerated by two patients with pulmonary tuberculosis, having great promise but still in the experimental stage.

At the close of Dr. Cooper's interesting paper, Capt. H. E. A. Cavanagh, attached to the England General Hospital, narrated some of his experiences as a Medical Officer in the Southwest Pacific.

## BURLINGTON COUNTY

T. B. Dickson, M.D., Reporter

On March 8, 1945, the *Burlington County Medical Society* held its regular monthly meeting at the Burlington County Hospital, Mt. Holly. Dr. Hammell Shipps read a letter from the Camden County Medical Society which endorsed DR. J. HOWARD HORNBERGER for Second Vice-President of the State Society.

The Burlington County Medical Society went on record to support the National Physicians Committee and sent a check for fifty dollars to the treasurer of the Committee.

Dr. Thomas Summey introduced the guest speaker, DR. R. MANNING CLARKE, Professor of Medicine at the Women's Medical College, Philadelphia. Dr. Clarke spoke on "Functional Diseases of the Colon". It was an intensely interesting talk on a topic which is not very clearly understood by many physicians. Lantern slides were used to illustrate the lecture.

## CAMDEN COUNTY

Joseph C. Lovett, M.D., Reporter

The monthly meeting of the *Camden County Medical Society* was held March 6, 1945, at the Cooper Hospital in the staff room with DR. HENRY B. DECKER presiding. There were forty-eight members present.

DR. PAUL MECRAY conducted the staff meeting.

The first case was one of DR. THOMAS K. LEWIS' "Pneumococcic Meningitis—type III pneumococcus" presented by Dr. Halbersen. Otitis media developed, incision of drum and finally a mastoidectomy —type III pneumococcus being the organism found in the mastoid.

The patient received large doses of penicillin intramuscularly and intrathecally, as well as sulfadiazine. The patient also had a blood transfusion.

Total dosage of penicillin was 3,200,000 units intramuscular and 85,000 intrathecal. The patient is now well on the road to recovery.

Dr. Lewis, in discussing the paper, compared the results of the present treatment with that before we had penicillin and sulfonamide drugs.

Dr. Ernest G. Hummel reported two cases of meningitis from the Children's Service. Both were pneumococcic—one being type XIV. Both patients recovered. One had total blindness and deafness, but after three months showed improvement in sight and hearing.

Dr. William T. Read, Jr., in discussing Dr. Lewis' case stated there were so many organisms he was very doubtful about recovery.

Dr. O. R. Carlander presented the next case. "Malignant Synovial Carcinoma—A Synovioma". It started two years ago with a mass developing on the outer side of the ankle, no tenderness, no redness and was not attached to the skin. X-ray showed soft tissue swelling on external malleolus. Patient was operated January 3rd, x-ray therapy was used two weeks after operation and cast was removed in four weeks. These are very rare tumors. They originate in the synovial tissue found in and near joints. There are only twenty-seven authentic cases reported. Cause is a chronic inflammation. Duration of symptoms average thirty-six months and they are not characteristic. Treatment is excision or amputation and probably x-ray.

Dr. Read discussed the case from the pathological side and showed lantern slides of the tumor. He advised amputation as soon as possible as there is great danger of metastases.

Dr. Thomas M. Kain read a paper on "Subacute Bacterial Endocarditis Following Rheumatic Fever". This patient had had a heart condition at least a year before present attack. On admission the blood cultures were positive for streptococcus viridens. She was given 300,000 units of penicillin daily. Temperature came down to normal and subsequently there was a negative blood culture. Since discharge the patient has resumed her normal duties. There has been no relapse and the patient feels all right. This patient must be checked periodically to make sure of a cure. There has never been a cure of this condition and while the patient feels well the condition is really serious.

The paper was discussed by Dr. Lewis. It will take time to tell if there has been a cure. It is impossible to carry the penicillin or sulfa drug by the blood to the infected area. Aminophyllin has been used to dilate the blood vessels so the drug may be more effective.

Dr. Ralph K. Hollinshed discussed the various strains of the streptococcus viridens. Some strains are responsive to penicillin. The use of heparin is not without danger and the results are just as good without it.

Dr. Read told of the tests for the strains of streptococcus viridens. Penicillin gives the best and only hope at present.

Dr. Robert S. Gamon showed x-ray films, showing the use of coligrams in common duct obstruction. Three cases were presented. The paper was discussed by Dr. Irvin E. Deibert, who congratulated Dr. Gamon as these are very difficult cases. Dr. H. Wesley Jack, in discussing the paper, brought out that there is always a question of whether a stone or a malignancy is present.

Dr. Arthur G. Pratt presented a case of "Calcinosis Cutis". This was a boy with masses on legs, arms and one buttock — some discharging. Biopsy showed a greyish-white pasty fluid. X-ray showed calcium deposits only in the skin and subcutaneous tissue. There are two varieties of this disease—spontaneous, as in this boy, and in the elderly, occurring with wasting disease. Treatment has not been effective.

Dr. Read, in discussion, stated this is a rare disease. There is a chronic inflammatory condition with calcium deposits. It can be confused with T. B. Dr. Decker, in discussion, stated it was some fault in fat metabolism.

Dr. James S. Shipman spoke on the Insurance Program and urged the members to fill out their applications.

Dr. Thomas B. Lee reported on the Freeholders asking for help at the Lakeland Hospital. Inspection of the hospital was made as well as recommendations. It was moved and passed that the recommendation of the committee be accepted.

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## HUDSON COUNTY

Harry J. Perlberg, M.D., Reporter

A regular meeting of the *Hudson County Medical Society* was held on March 6, 1945, at the Masonic Club, Jersey City, with Dr. Walter D. Weber presiding.

Dr. J. L. Evans read the following nominations for 1946:

President: Hugh H. Tyndall
Vice-President: Claudio E. McNenney
Treasurer: Anthony J. Conty
Secretary: Vincent P. Butler
Reporter: Harry J. Perlberg

Board of Trustees:
William J. Gleeson (three years to 1948)
David I. Nalitt (to complete unexpired term of W. L. Williamson, deceased)

Board of Censors (three years to 1948)
R. L. Ballinger

Audit Committee (three years to 1948):
H. B. Ainsley

Publication Committee (three years to 1948):
P. Kresch — Gerald W. Sinnott
N. M. Alter — Noah Meyerson

Delegate to State Nominating Committee (to serve in 1946)
James F. Norton

Alternate to State Nominating Committee (to serve in 1946):
J. Lawrence Evans

Committee on Constitution and By-Laws (three years to 1948):
A. C. Ruoff

Election Committee (to serve in 1946):

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|---|---|
| S. G. SCOTT | WILLIAM M. DOODY |
| J. C. TALTY | MAURICE SHAPIRO |
| L. A. SCHNEIDER | SAMUEL S. SCHEPT |

J. J. DANIELSON

Legislative Committee (three years to 1948):

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|---|---|
| MAURICE SHAPIRO | GEORGE GINSBERG |

WALTER D. WEBER

Maternal Welfare Committee (three years to 1948):

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|---|---|
| JAMES F. NORTON | SAMUEL A. COSGROVE |

JAMES A. MCCARRON

Delegates to State Convention (three years to 1948):

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|---|---|
| E. J. CHAPMAN | R. L. BALLINGER |
| T. J. SCHUCK | C. J. LARKEY |
| B. S. POLLAK | JOHN S. MADARAS |
| S. A. COSGROVE | GEORGE GINSBERG |
| J. L. EVANS | W. W. MAVER |

A. C. RUOFF

Alternates to State Convention (three years to 1948):

| | |
|---|---|
| E. E. LUPIN | S. KOOPERSTEIN |
| HAROLD SAGER | W. J. SNYDER |
| J. J. O'CONNOR | P. J. BONANNO |
| H. FIALK | H. A. GRANELLI |
| A. SCHLEIN | J. N. CONNELL |

DR. A. C. RUOFF, Chairman of the Accident and Health Insurance Committee, announced that the progress of the campaign to obtain the required 50 per cent enrollment in the Group Plan of Accident and Health Insurance—while considered satisfactory by the insurance representative, Mr. Blanksteen, is not quite to the point anticipated by the committee at this stage. He urged that all who wish to avail themselves of the benefits of this special policy *postpone no longer* the sending in of their applications, as March 15th is the date set by the company for the termination of the campaign.

Dr. Butler read a communication from Mrs. Edith L. Madden, Acting Executive Officer, The Medical Society of New Jersey, announcing that the War Convention Committee in Washington has denied permission to hold our 1945 annual meeting in Atlantic City, and consequent cancellation of all arrangements.

Regarding the recommendation of the Executive Committee that our Society recognize in fitting manner the services of DR. JOSEPH F. LONDRIGAN to The Medical Society of New Jersey, it was regularly moved, seconded and carried that a committee be appointed, consisting of the President and Secretary, for the accomplishment of this objective.

DR. HARRY J. PERLBERG, Chairman, Jersey City Chapter American Red Cross, introduced the guest speaker, MISS MARIE CARROLL, Overseas Field Director.

Miss Carroll was exceptionally interesting, relating many of her personal experiences in Red Cross, as well as describing the general activities of this humanitarian organization which is accomplishing so much in maintaining the morale of the men in actual combat and also during their brief periods of relaxation. A short motion picture on the same subject followed Miss Carroll's talk.

Dr. Perlberg complimented Miss Carroll and thanked her in the name of the Society. He expressed the hope that when making out their checks to the Red Cross, some incident related by Miss Carroll will come to the minds of his hearers, inspiring them to make the amount of their checks substantial.

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## MONMOUTH COUNTY

Elsworth F. Baker, M.D., Reporter

The regular meeting of the *Monmouth County Medical Society* was held in the Library of the Monmouth Memorial Hospital, Long Branch, on Wednesday evening, February 21, 1945. The meeting was called to order by the President, DR. OTTO HOLTERS. The reading of the minutes was dispensed with and Dr. Harold Freedman was asked to introduce the speaker of the evening, DR. EDWARD HARTUNG, Chief of the Arthritis Department, Post Graduate Hospital, New York City. The topic of the evening was "Rheumatoid Arthritis".

Dr. Hartung stated that this was the least interesting of all the subjects in the rheumatic field as the results were most productive in the other fields. Unchecked rheumatoid arthritis leads to the wheelchair. There are many other forms of rheumatism, for example, *osteo-arthritis,* which is universal, starting at the age of 40 and stands with arteriosclerosis as a cause of disability among the degenerative diseases. It is due to a wearing out of the cartilage and although incurable, pain can rapidly be relieved. Rapid strides are being made in *acute rheumatic fever* both by the use of sulfonamides and large doses of sodium salicylate from 150 to 300 grains a day given in the vein at first. This prevents cardiac complications.

Essentially no advance, however, has been made in *gout* during the past 2000 years except to push colchicine, which Hippocrates used in his therapy. 1/100 grain is given every four hours until diarrhea develops. In the first ten years of gout, this treatment is specific. Then there are the arthritides due to specific infection such as gonorrhea and tuberculosis. Those due to gonorrhea are disappearing with the use of sulfa drugs and penicillin. Joint tuberculosis is rare. The other forms due to specific infections such as staphylococcus, streptococcus and pneumococcus infections are rare.

We now come to rheumatoid arthritis. This is a non-articular rheumatic condition and is essentially the same as fibrositis which covers a vast field. It may be: (a) traumatic; (b) static, due to poor body mechanics such as flat feet.

Rheumatoid arthritis is a disease of the fibrous tissues, a collogen degeneration. The pathology is similar to lupus erythematosus, scleroderma and other allied conditions. Fibrous tissue is not just a filling but an important dynamic structure. It is concerned with mediating the nutrition of the body. The basic pathology for collogen degeneration consists of a swelling, cloudiness and change in tissue and dye reactions. This is followed by a

proliferation of fibro blasts which forms rheumatic nodules, essentially the same as those in rheumatic fever. Examination of the patient is important. This is not primarily an orthopedic disease but rather a disease of internal medicine. The following examinations are necessary:

1. Complete internal medical survey.
2. Specific search for foci of infection.
3. Thorough orthopedic examination.
4. Record of the amount of disability.
5. Laboratory data:
   a. Sedimentation rate.
   b. Complete blood count.
   c. Urinalysis.
   d. Blood uric acid.
   e. X-rays of the joints most affected.
   f. Culture of synovial fluid when specific arthritis is suspected.

The blood uric acid examination is made to rule out gout, which is a common disease. X-rays should be made especially of the metatarso-phalangeal joints. Pains in the feet are usually the first symptoms. In rheumatoid arthritis one finds a high sedimentation rate, an anemia of the blood; the urine is usually negative.

Treatment consists of the following:

1. Constitutional rehabilitation.
2. Gold Salts.
3. Transfusions.
4. Prevent deformities.
5. Treatment of deformity.

Rheumatoid arthritis is believed to be a chronic infectious disease.

1. Constitutional rehabilitation provides for the following:
   a. Treatment of any derangement of the body.
   b. Rest, both general and local—ideally rest should consist of sanitarium treatment for a period of two to five years but actually cases are so restricted only if fever is present.
   c. Proper nutrition with a well balanced high vitamin diet and adequate teeth to chew the food.
   d. Proper gastro-intestinal function — hydrocholoric acid when indicated and proper bowel elimination. When there is ulcerative colitis present, a colostomy frequently relieves symptoms very quickly.
   e. Iron for the anemia.
   f. Correction of postural defects, especially weak feet.

There is no basis for the use of vaccines from a scientific standpoint since we still do not know the cause of rheumatoid arthritis.

2. *Gold Salts* are a standard treatment and the most important single measure in arresting the progress of the disease. During the first six months of the illness 60 per cent get well of their own accord even without treatment but after one year not one-half of one per cent get well without some therapy. Gold Salts are given only when a positive diagnosis of rheumatoid arthritis is made to justify the risks of this therapy so that they are not given until the disease has been present for a period of at least three months. The contraindications of this therapy are:
   a. Disseminated lupus erythematosus.
   b. Acute rheumatic fever.
   c. Renal impairment.
   d. Blood dyscrasias.

The two Gold Salts most frequently used are: Solganol B (Schering) and Myocrysine (Merck). Both of these salts have 50 per cent metallic gold. The usual dosage runs as follows:

10 milligrams of the Gold Salt the first dose;

25 milligrams the second dose;

50 milligrams thereafter every three to seven days until a total of 1000 to 2000 milligrams have been given. This is continued for two to three years, being given once a month during the second and third year. This method cuts down the frequency of recurrences. The two Gold Salts mentioned above are given intra-gluteally.

The toxic effects are as follows:

1. Pruritis.
2. Dermatitis.
3. Stomatitis.
4. Renal irritation with albumin and red blood cells in the urine.
5. Leucopenia.
6. Neutropenia.
7. Thrombopenia with or without purpura. This is the complication that may lead to death.
8. Toxic hepatitis.

These are really not toxic effects at all but are due to a hypersensitivity. This may appear at any time and the effects may last from two days to a year. It is frequently possible to continue the Salts after the effects clear up.

Number seven is the most important toxic effect and causes a mortality of one-half of one per cent. Because of the toxic effects one should take the following precautions before each injection:

a. Question the patient as to itching of the skin.
b. Examine the skin for rash or purpura.
c. Examine the mouth for stomatitis.
d. Examine the urine for albumin and red blood cells.
e. Every two weeks a white count, differential and hemoglobin should be done.

Gold Salts produce a marked bacterio-static effect in the tissue fluid of treated patients. In a few months after stopping treatment, the tissues lose this effect. There is no excretion of gold in the saliva and very little in the stool. The majority is eliminated slowly in the urine. Gold is retained in the body over long periods of time and on some cases followed there was still gold in the urine 270 days after treatment was stopped. This also accounts for the length of the toxic effects one finds in this treatment. Nothing has been found to accelerate the excretion of gold.

3. *Transfusions* when given should consist of 500 c.c. of whole blood once a week for 12 weeks.

The rationale of transfusions are:

a. To ameliorate chronic anemia.
b. Correct the disturbed albumin globulin ratio.
c. The production of non-specific protein shock.
d. Transference of passive resistence.

4 & 5. The prevention and treatment of deformities give a great field for therapy. Much can be done in the way of rehabilitation especially by orthopedic surgery.

Dr. Hartung showed numerous slides to illustrate the pathology of rheumatoid arthritis. During the discussion, which consisted chiefly of questions, Dr. Hartung stated that still very little is known about this disease since pregnancy is one of the greatest temporary cures which remains until the third month of lactation. Toxic jaundice may also clear up the symptoms temporarily. Psychotherapy may be of value in treating the disease itself, but surely is of value in adjusting the individual to his condition.

A vote of thanks was offered to Dr. Hartung for his very interesting and instructive talk.

The following business was transacted. It was decided to provide an allowance of $50.00 a month for several months toward the care of one of the unfortunate elderly physicians in the county until permanent adequate care can be arranged.

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## PASSAIC COUNTY

J. Reuben Budd, M.D., Reporter

The regular meeting of the *Passaic County Medical Society* was held at the Board of Freeholders' Meeting Room in the Administration Building, Paterson, on February 20, 1945. The meeting was called to order by the President, DR. WILLIAM SULLIVAN.

Dr. Sullivan introduced the speaker, DR. LLOYD F. CRAVER, Attending Physician to the Memorial Hospital for the Treatment of Cancer and Allied Diseases, New York City, and Assistant Professor of Clinical Medicine, Cornell University Medical College. The subject was "Blood Dyserasias". In view of the vastness of this subject, Dr. Craver limited his discussion to the leukemias. The newer theories as to the possible etiology of the disease were discussed.

The objective symptoms were demonstrated by lantern slides. Especially interesting was the demonstration of the skin and oral manifestations. The advantages of whole-body radiation and the use of radioactive phosphorus were brought out. Dr. Craver emphasized the value of complete blood counts in routine physical examination check-ups, pointing out the often insidious onset of the disease.

DR. JOSEPH MARTINI, President of the Passaic County Dental Society and Chief of the Oral Surgical Staff at St. Mary's Hospital, Passaic, N. J., discussed the paper. Dr. Martini urged the need for close coöperation between the dentist and the physician.

A resolution on the death of DR. ARTHUR WARD VAN RIPER was read and unanimously adopted.

## SUMMIT MEDICAL SOCIETY

Carroll S. Thomson, M.D., Secretary

The *Summit Medical Society* held its second meeting of the season on November 28, 1944 at 9:00 p.m., at Ciba Pharmaceutical, Inc., Summit, with DR. M. S. EDGAR, President, presiding. Twenty-three members and ten guests were present. Invitations were sent to several hospitals, inviting their staffs to attend the meeting.

DR. NORMAN JOLLIFFE of New York City gave a very interesting and instructive paper on vitamins, the subject being "A Modern Concept of Malnutrition and Principles of Therapy".

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The *Summit Medical Society* of Summit, N. J., held its third meeting of the season on Tuesday, January 30, 1945, at the Ciba Pharmaceutical Products, Inc., with twenty-one members and ten guests present. So far there has been a better attendance this year than in the last two years.

Two important matters were brought to the attention of the members: The request of the local Veterans Service Committee that the physicians cooperate with them in the care of veterans and their families, at a fee agreed upon; and a possible establishment of a Mental Hygiene Clinic. Suitable action was taken on these matters.

The speaker of the evening, DR. GRANT THORBURN, Chief of the Chest Service, Lenox Hill Hospital, New York City, was then introduced by Dr. Tidaback, our Vice-President. The subject of Dr. Thorburn's paper was "Diagnosis and Treatment of Chronic Pulmonary Disease". The paper was presented in a very able manner and very fully illustrated with numerous slides.

A collation followed the meeting. These meetings have been very interesting and instructive. Ciba serves a very bountiful collation, and all physicians and dentists are cordially invited to attend. Also all members of the Army and Navy Medical Corps are invited to attend these meetings which are held on the last Tuesday of each month, from October to May inclusive.

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The fourth meeting of the *Summit Medical Society* was held on February 27, 1945, in the lecture room of Ciba Pharmaceutical Products, Inc. Twenty-two members and ten guests attended.

DRS. T. P. PROUT and C. B. KEENEY were appointed to draw up a set of resolutions on the life of the late DR. H. D. JAMISON. In the absence of Dr. Keeney Dr. Prout presented the resolutions, which were accepted by the Society. The President ordered a copy of same sent to Dr. Jamison's widow and a copy placed on the minutes of the Society.

DR. W. J. HALLOCK of Summit was appointed as the official representative of the Summit Medical Society on the advisory board of the Local Veterans Service Committee.

The paper of the evening, "Ruptured Intervertebral Discs", was presented by DR. BRONSON RAY, Associate Professor of Surgery, Cornell Medical School, and evoked much discussion.

# WOMAN'S AUXILIARY

## PRESIDENT'S SPRING MESSAGE

Mrs. David B. Allman

Among the many disappointments occasioned by the war is the cancellation of our Annual Meeting at the Government's request.

It has been at these meetings during the past eighteen years that we have been able to renew old acquaintances and to make new friends. At those times we were able to develop new ideas for the future of our Auxiliary and to iron out any existing difficulties. It is indeed a distinct loss to us to be unable to hold our Annual Meeting; but if by foregoing this privilege we can hasten victory by even so much as one hour, we gladly acquiesce.

The past year, I feel, has been a happy and a prosperous one for our Auxiliary. We have all worked in harmony for the common cause, and I feel that we have developed the maximum amount of light on all subjects with a minimum of friction and heat.

We are particularly fortunate this year in that even though there be no elaborate meeting and not much in the way of formal ceremonies there will be no great hiatus when I turn the gavel of authority over to my successor. As most of you know, Mrs. Dodd has accompanied me on most of my official visits and the knowledge she has thus acquired, plus her natural abilities and fitness for the position, will make her, I am sure, one of the most efficient and best liked Presidents we have ever had. In her hands the affairs of our Auxiliary are safe.

Not having our Annual Meeting will deprive me of personally thanking individually all the members of the Auxiliary who have at all times been so kind to me and so generous in their support. I shall leave office with many regrets, for in leaving I will lose close contact with many loyal supporters and friends, but I shall leave with many more pleasant memories of splendid support and of loyal friendships developed. I cannot thank enough all those who labored so diligently with me through the year, and for the many kindnesses and words of encouragement I have had from all.

I bespeak for the President-Elect the same fine support and coöperation you have given me. This I am sure she will receive and with it, and with what we hope will be a "Post-War Era", I am certain that Auxiliary matters will go ever forward.

## ORGANIZATION

Mrs. J. Howard Hornberger, Chairman

Today, with the world involved in the worst conflict of all times, women everywhere are asking how they can best help to bring about complete and final victory over our enemies. Many have found their answer by joining the Women's Services of the Army, Navy, Marines, and Nurse Corps. Others have accepted positions in War Work, Red Cross, U. S. O. and numerous other war services.

However, the public looks to the medical profession for instruction in prevention and control of disease. So the women look to physicians' wives for guidance along the same line. Hence doctors' wives must be prepared to assume leadership in their social activities. This is best accomplished by active participation in Auxiliary, and all club work where matters of health are discussed.

Now as never before, we should strengthen our present auxiliaries, and whenever possible organize new ones. This need will increase as "Victory" nears, and plans for the post war period must be ready. Many times you hear the assertion that doctors' wives are too busy, that they are over-organized. You may belong to many organizations, but your local auxiliary should be your first thought. Many of these other groups no doubt have health programs, but here is your opportunity to serve your Auxiliary. Arrange to serve as the chairman of this committee, so that the health information discussed is authentic and properly presented.

Many counties have worthy projects which tend to stimulate interest in your Auxiliary; however bear in mind the fact that the chief

function of an Auxiliary is to educate the public in all health matters. Of course to do this, you first must be informed, and have the sanction of your respective medical society to discuss the subject.

Continue to hold meetings frequently, for otherwise interest will lag, and soon there will be no Auxiliary. Let us continue our good work, so that we are united and ready whenever the need arises.

## HYGEIA

Mrs. F. G. Wandall, Chairman

Hygeia, the A. M. A. health magazine, is a "must" in almost all physicians' waiting rooms these days. Hygeia gives health information, but each article emphasizes the intrinsic value of "Your Family Physician". Hygeia gives reliable information regarding quacks, faddists and cultists. It is a safeguard against ignorance. The American public squanders more than four million dollars annually on patent medicines. Consequently it is vitally important that our Auxiliary to The Medical Society of New Jersey promote distribution of this magazine to help the physicians in their fight for preventive medicine, and to educate the American public in correct and safe health education.

The counties have done more this year for the distribution of Hygeia than any year since the Auxiliary in New Jersey was founded—so, with such progress and marked increase in interest, the distribution will be even greater next year.

## SAFE AT HOME

### NEWARK SAFETY COUNCIL (WOMEN'S DIVISION)

Mrs. Lodovico Mancusi-Ungaro, Representative of the Auxiliary

Home is where we feel most safe. There among the surroundings we know best, in the company of those whose welfare is our deepest concern, and to whom our well-being is of the greatest importance, there if anywhere, we should be safe. Ironically enough, statistics show that home is the place where we are least safe. 1944 produced these shocking figures: In that one year more than 30,000 people were killed and over 4,600,000 were disabled by home accidents.

We know our homes so well. We are so accustomed to the worn step, the dark passageway that we believe our familiarity with our surroundings will be sufficient armor to ward off accidents. Comes a day, however, when we are completely off guard and the sagging step or unlighted hall is the cause of a serious accident.

Undoubtedly these are unusual and difficult times. People are living under heavy pressure. Tension has increased. There is the worry over absent ones—many of them in acute and constant danger. There is the difficulty and delay in getting things done, especially repair work around the house. Household tasks have increased for many of us. There are the outside duties we have taken on. Is it any wonder our minds are not always on what we are doing, that many of our tasks are performed with too much speed for safety? The seriousness of the times, however, should make us more than ever cautious. We must not add to the inevitable waste of war by a senseless waste of life or a lessening of our capacities through accidents, which a little commonsense and caution could prevent.

A check-up of our homes may reveal many accident hazards. Some of these exist because our own inertia has kept us from taking preventive measures. By taking definite steps to correct these hazards, we can help to reduce the annual toll of accident in this country.

## EXECUTIVE BOARD MEETING

The Executive Board of the Woman's Auxiliary to The Medical Society of New Jersey held a regular meeting Monday, March 12th, at the Executive Offices of The Medical Society of New Jersey in Trenton. Mrs. David B. Allman of Atlantic City, President, presided. Following the business those present were guests of the Auxiliary at buffet luncheon.

Mrs. A. Haines Lippincott of Camden, New Jersey Commander for the American Cancer Society, spoke of the coming cancer drive and urged the Auxiliary to participate in this movement. Mrs. Max L. Weimann of Haddon Heights gave a comparative book review on "As I Remember Him" by Dr. Hans Zinsser and "A Surgeon's World" by Dr. Max Thorek.

Dr. Joseph F. Londrigan, President of The Medical Society of New Jersey, spoke to the Woman's Auxiliary and said that a committee has been formed in the State of New Jersey, known as the New Jersey Committee of the National Physicians Committee. This committee expects to have, some time in June, a meeting in each one of the Councilor districts of the State, to which will be invited medical men, all of the allied medical groups, civic and welfare groups, industry and labor groups, and religious and women's groups of each district to hear Mr. Edward W. Stegen of Chicago who is assistant administrator of the National Physicians Committee.

Dr. Londrigan, complimenting the work of the Auxiliary, said that he felt that the Auxiliary could be of vital help to the Medical Society by acting as liaison agents between the Medical Society and the public, especially among the women's groups of the state.

## FUTURE EVENTS

ATLANTIC — The Woman's Auxiliary to the Atlantic County Medical Society will hold a regular business meeting Friday, April 13, at 2:00 p. m. at the Madison Hotel. Miss Luella Koons will speak on "The History of Silver". Mrs. Charles Hyman will be the program chairman.

ESSEX—The Woman's Auxiliary to the Essex County Medical Society will hold a joint supper meeting with The College Woman's Club of Essex County at 6:30 p. m., Monday evening, April 23, 1945, at The Academy of Medicine, Newark. Following supper, each club will separate for a short business meeting, and at 8:00 p. m. they will reunite for a health program. Dr. Joseph I. Echikson, Chairman of the Cancer Committee of the Essex County Medical Society, will speak on "Cancer". Following his talk Mrs. A. Haines Lippincott, State Commander for the New Jersey Division of the American Cancer Society, will show the film "Hope in Cancer" and speak of the work of the American Cancer Society.

GLOUCESTER—At 9:00 p. m., Thursday, May 17, 1945, the Woman's Auxiliary to the Gloucester County Medical Society will hold its regular business meeting at the home of its President, Mrs. H. B. Diverty, 44 Cooper Street, Woodbury.

MONMOUTH — The annual meeting and the election of officers will take place on Tuesday, April 10, 1945, at Auxiliary Hall, Bath Avenue, Long Branch.

PASSAIC—The Woman's Auxiliary to the Passaic County Medical Society will hold an open meeting of the Auxiliary to which the public will be invited at the Paterson Library, 250 Broadway, Paterson, Monday evening, April 16, 1945, at 8:30 p. m. Dr. Julian Cohen, Chairman of the Heart Disease Committee of the Passaic County Medical Society, will discuss the "Need of a Rheumatic Heart Foundation in Passaic County".

## AUXILIARY REPORTS

### Atlantic County

Mrs. Samuel Salasin, Chairman of Publicity

On Friday, March 9, 1945, members of the *Woman's Auxiliary to the Atlantic County Medical Society* met for luncheon at The Madison Hotel to complete plans for the arrangements for the Spring Card Party. Plans were also made for members of the County Auxiliary to go to the State Auxiliary meeting in Trenton on Monday, March 12, 1945.

Light chatter filled the Madison Hotel Solarium as the Auxiliary met for its Spring Bridge Party Wednesday, March 14, 1945. Mrs. Anthony Meren-

dino and Mrs. V. E. Johnson were co-chairmen of this very successful party.

The appointment of Mrs. Robert Salasin of Margate City as general chairman of the civilian committee to speed up WAC recruitment by Graham Ferry, Civilian Defense Administrator for the Atlantic City area, brings to the fore one of the Atlantic County Auxiliary's youngest and newest members.

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### Essex County

Mrs. Rocco Marra, Chairman of Publicity

A Board Meeting of the *Woman's Auxiliary to the Essex County Medical Society* was held at the Academy of Medicine on February 26, 1945, at 11 o'clock, followed by the regular meeting at 2 o'clock. The President, Mrs. Lodovico Mancusi-Ungaro, presided. Dessert, which included a very delicious rum cake donated by Mrs. Mancusi-Ungaro, was served by our hostess committee. Our guest was the well-known beauty authority and lecturer, Miss Morena, a representative from the Elizabeth Arden Salon, who spoke and demonstrated to us the numerous ways to become beautiful. She showed us how to improve our appearance with the proper appliance of makeup, and how to acquire slimness and good grooming by continuous exercise. I am sure all the women will agree that Miss Morena's topic was very interesting, and that an enjoyable afternoon was had by everyone. We were happy to see such a large attendance.

The Chairmen of Membership, Mrs. Don A. Epler and Mrs. Irving Berney, reported 38 new members to date.

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### Gloucester County

Mrs. C. A. Bowersox, Press and Publicity Chairman

The *Woman's Auxiliary to the Gloucester County Medical Society* sponsored a "Message of Hope" meeting in the Court House Room, Woodbury, on March 15, 1945, at 8:30 p. m.

Mrs. H. B. Diverty, President of the Auxiliary, extended a welcome to over 100 attending. Mrs. Diverty introduced Dr. Harris Underwood, who gave a brief talk on the accomplishments of the American Cancer Society, under the able direction of Mrs. A. Haines Lippincott, State Commander of the New Jersey Division Field Army.

Mrs. Lippincott, an outstanding authority from the standpoint of knowledge and practice, spoke on many phases of cancer work. She stressed the fact that the public must help educate itself by dispelling fear, delay and ignorance. A triple program of education, humanitarianism and research was presented.

Two films with sound, "I Choose to Live" and "Enemy X", were shown.

Those serving on the committee were Mrs. C. A. Bowersox, Mrs. H. B. Diverty, Mrs. Fred Faux, Mrs. J. F. Hughes, Mrs. B. A. Livengood and Mrs. Harry Nelson.

### Mercer County

Mrs. C. Chester Chianese, Chairman of Publicity

The *Woman's Auxiliary to the Mercer County Medical Society* held a short meeting at the Medical Society Executive Offices on Monday, March 12, 1945, following the State Board Meeting. Mrs. H. Donald Cowlbeck, President, presided.

The War Participation Committee gave a report on the work being done by our members at this time.

Plans for the April meeting were discussed informally. In order that we enrich the treasury and encourage sociability among our members, a motion was made and seconded that a card party be given following luncheon. Mrs. Patrick H. Corrigan is Chairman of Entertainment.

Mrs. Thomas V. Murto and Mrs. G. S. Usher were welcomed as new members.

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### Middlesex County

Mrs. N. Rosenberg, Chairman of Press

The March meeting of the *Woman's Auxiliary to the Middlesex County Medical Society* was held on Wednesday evening, March 21, at 8:30 p. m., at the home of Mrs. L. A. M. Feher, 177 Somerset Street, New Brunswick. This was the first meeting of the Auxiliary since January, as it was agreed by the group to eliminate the February meeting.

Mrs. F. M. Hoffman and Mrs. B. M. Howley served as hostesses for the occasion.

An Auction Sale was held and Mrs. Charles F. Merrill conducted the business meeting.

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### Monmouth County

Mrs. Maxwell Colby, Chairman of Publicity

Mrs. David B. Allman, President of the Woman's Auxiliary to The Medical Society of New Jersey, Mrs. William E. Dodd, President-Elect, and Mrs. J. Howard Hornberger, Organization Chairman for the Woman's Auxiliary, were guests of honor at a spring luncheon and meeting of the *Woman's Auxiliary to the Monmouth County Medical Society*, March 13, 1945, at Joseph's Restaurant in West Long Branch. Mrs. Joseph Bossone, President of the Monmouth County Auxiliary, presided.

After explaining the organization and the success of the blood donor service of the Ocean County Auxiliary, Mrs. Dodd expressed her desire for a similar organized service in Monmouth, administered by the local Woman's Auxillary to the Medical Society.

Mrs. Hornberger explained the necessity of a physician's wife participating in the Auxillary of her husband's profession, no matter how busy or otherwise absorbed she may be.

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### Passaic County

Mrs. Irving Silverman, Chairman of Publicity

The regular business meeting of the *Woman's Auxiliary to the Passaic County Medical Society* took place Monday, March 19, 1945, at the home of

Mrs. Dean A. Wry, 141 Washington Avenue, Clifton. The President, Mrs. Joseph E. Mott, presided.

Committee reports were given by the following: Press and Publicity, Mrs. Irving Silverman; Membership, Mrs. James S. Gallo; Camp and Hospital, Mrs. A. M. Schultz; Legislation, Mrs. H. H. Hollingsworth; and a report of the recent State Auxiliary meeting in Trenton, Mrs. Richard McDonald.

There was much discussion about the new project "The Rheumatic Heart Foundation". It was decided to hold an open meeting to which the public should be invited. (See Future Events.)

Mrs. Mott appointed Mrs. Morris S. Joelson as Chairman of the Spring Card Party, the proceeds of which will be used for the Philanthropic Fund. Mrs. Peter J. DeBell was appointed chairman of the next meeting, which will be the annual luncheon.

Following the business meeting Mrs. Richard E. White reviewed the book "The Immortal Wife" by Irving Stone. Tea was served at the end of the afternoon.

**Warren County**

Mrs. Herman Baldauf, Chairman of Publicity

The *Woman's Auxiliary to the Warren County Medical Society* met at luncheon at the Meadowview, Phillipsburg, on February 19, 1945. The business meeting was presided over by the President, Mrs. F. A. Shimer.

Plans for the annual card party to be held at the Hotel Easton on March 17, 1945, for the benefit of the Warren County Hospital were completed. Following the business meeting the members present played cards.

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The third annual bridge, sponsored by the *Woman's Auxiliary to the Warren County Medical Society,* was held Saturday afternoon, March 17, 1945, at the Hotel Easton for the benefit of the Warren Hospital, with Mrs. F. A. Shimer as chairman. There were approximately 72 tables.

St. Patrick's Day decorations which had been made by the elementary grades of the Belvidere School were used throughout the hall.

## BOOKS RECEIVED FOR REVIEW

Internal Medicine; Its Theory and Practice in Contributions by American Authors. Ed. by John H. Musser, B.S., M.D., F.A.C.P. 4th ed. Philadelphia, Lea & Febiger. 1945. $10.00.

Arterial Hypertension; Its Diagnosis and Treatment. By Irvine H. Page, M.D., and Arthur Curtis Corcoran, M.D. Pp. 352. Chicago, Year Book Publishers, Inc. 1945. $3.75.

Dentist and His Patient; A New Concept of Dental Practice. By David Friend, Executive Director, The New Organization, Inc.; George D. Kudler, D.D.S.; Myron M. Lieb, D.D.S.; Robert Ritt, D.D.S., and Arthur A. Friend, D.D.S. Pp. 480. New York, Revere Publishing Company. 1944.

Military Medical Manuals—A Manual of Tropical Medicine. Prepared under the Auspices of the Division of Medical Sciences of the National Research Council. Pp. 727 with 284 illustrations. Philadelphia, W. B. Saunders Company. 1945. $6.00.

Medical Gynecology. By James C. Janney, M.D., F.A.C.S. Pp. 389 with 97 illustrations. Philadelphia, W. B. Saunders Company. 1945. $5.00.

Peripheral Nerve Injuries. By Webb Haymaker, Capt. M.C., A.U.S., and Barnes Woodhall, Maj. M.C., A.U.S. Pp. 227 with 225 illustrations. Philadelphia, W. B. Saunders Company. 1945. $4.50.

## BOOK REVIEW

**Minor Surgery.** By Frederick Christopher, S.B., M.D., F.A.C.S. 5th ed. Pp. 1006 with 575 illustrations. Philadelphia, W. B. Saunders Company. 1944. $10.00.

This book needs no introduction to its hosts of friends. Since its first printing it has proved to contain sound, conservative guidance in treating those diseases, injuries, and conditions of general practice that require surgery.

The 5th edition has been completely revised. Discussions of wound healing and wound treatment have been completely rewritten with special attention given to use of sulfonamides.

A new chapter has been added on preoperative and postoperative care, including discussions of shock and its treatment with blood, plasma and other agents; dehydration, hypoprothrombinemia, vitamin deficiency (including K), water balance, electrolyte requirements, protein requirements, treatment of hypoproteinemia with amino acids, use of Miller-Abbott tube, prophylaxis and treatment of postoperative thrombosis and embolism (including heparin and dicumarol), and postoperative urinary complications, including use of 1/6 molar sodium-R lactate to increase pH of urine during sulfonamide administration.

New material is presented on tetanus toxoid, treatment of varicose veins, ligation of femoral vein in thrombophlebitis, treatment of pilonidal sinuses, wire sutures in tenorrhaphy, hanging cast in fractures of the humerus, x-ray treatment of sprained ankle, "paratrooper fracture", walking casts, sternal infusions, etc.

Penicillin and its administration, and employment of plaster casts in wound treatment are given. The section on burns has been entirely revised and modernized including use of nonadherent pressure dressings and plasma administration.

This book is recommended as a handy guide to both surgeons and general practitioners.

Harold Hantman, M.D.

# Tuberculosis Abstracts

## *A Review for Physicians*

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

**Vol. XVIII** **April, 1945** **No. 4**

JOSEPH CONRAD once said, "A word carries far—very far—deals destruction through time as the bullets go flying through space." Medicine has a few such words. Too often these are used when a serious or potentially serious condition must be explained to an apprehensive patient. When words treacherously lull either the patient or the physician into a false sense of security, then words may ultimately maim or destroy as surely as if they were bullets.

### A SPOT ON THE LUNG

It is futile to search in dictionaries or medical text-books for a definition of the term "a spot on the lung." But the term is being used with great frequency by physicians, nurses and laymen alike. If this term is subjected to scrutiny, it is found that it may mean anything and everything that produces either a shadow or an area of decreased density in a chest roentgenogram or anything and everything that causes abnormal physical signs over the lungs. If, then, this expression has no meaning that cannot be stated more precisely in other terms, it remains to be found out why it is being used. If this is one of the terms that does not express a definite meaning, does it possibly obscure a meaning?

Nobody who has searchingly studied the histories of patients with pulmonary disease can doubt that the real function of the phrase, "a spot on the lung," is to cloud the facts. It is a cloak for a great variety of pulmonary diseases, a protective screen for the inability or unwillingness of the physician to arrive at a diagnosis acceptable to himself, a disguise for a bitter truth that the physician hesitates to tell the patient, an escape for the patient who tries to elude further diagnostic work and necessary treatment. After all, one does not die of "a spot on the lung," but one can die of bronchial carcinoma and one might die of pulmonary tuberculosis. Along with much other evasive, medical double-talk, "a spot on the lung" is a verbal mechanism of escape from reality. In the same category belongs the term "a touch of tuberculosis" and, improperly applied, "nothing but a little thickened pleura."

No physician needs to be told that "a spot on the lung" is no diagnosis. He realizes that it is evidence, on the one hand, of healed disease which calls neither for treatment nor for alarming its bearer, or, on the other, of active disease in need of treatment. The physician sometimes uses the term in patients in whom he has failed to establish, with a certainty that carries conviction for himself, the difference between active disease and obsolete scar. "A spot on the lung" has a pleasantly innocent sound. It lulls into inertia and indifference whatever doubts or curiosity the patient, and, even in some cases, the doctor may have. But still it is, for the physician, a mental reservation. It seems to beckon as a safe place to stand if "a spot on the lung" later turns out to be carcinoma, tuberculosis or bronchiectasis.

Admittedly, this judgment may be harsh. But I dare say that it will be resented only by those who, with the instrumentality of this ambiguous term, neglect their obligation of persevering until "a spot on the lung" has been accurately diagnosed. No person need be told that he has "a spot on the lung." If the condition is as clinically insignificant as the term suggests, the patient should be told that he has a scar from a previous tuberculous infection—one that needs an occasional check-up or one that needs no further observation. Or when the diagnosis is certain, the patient should be told that his lungs are normal. For, while "a spot on the lung" is often the obscured beginning of destructive disease, it is, in other cases, the starting point for tuberculophobia and anxiety neuroses, conditions that are no less

crippling and hardly more easily curable than tuberculosis itself.

But, though every reflecting physician knows that "a spot on the lung" is a meaningless and dangerous term, the utter convenience of the expression — and others like it — militates against their prompt extinction. Past experience justifies a pessimistic outlook. No amount and intensity of medical education are likely to eliminate entirely the term from medical parlance. Medical education however is being overtaken by the information that the public, including the prospective patient, is acquiring. People are learning to realize fully the confusing ambiguity of the term, they are beginning to refuse its acceptance just as an enlightened consumer protests against ambiguous and misleading labels on packaged goods. And the comparison is eminently proper: for all intents and purposes, "a spot on the lung" *is* ambiguous and misleading labeling. It may well be that through the protest of the consumer, by the refusal of every layman to be satisfied with the pseudo-diagnosis of "a spot on the lung" the term will eventually disappear.

It is high time for the medical and nursing professions and everyone engaged in tuberculosis work to bury a medical term that has quite literally buried so many patients.

*A Spot on the Lung, Max Pinner, M.D., The NTA Bulletin, January, 1945.*

SUPPLIED BY

New Jersey Tuberculosis League

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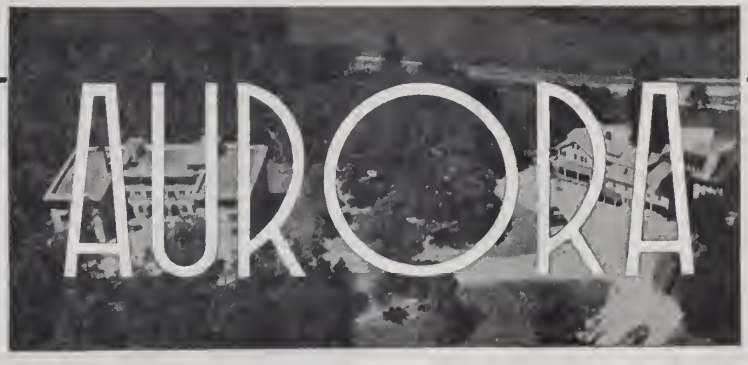
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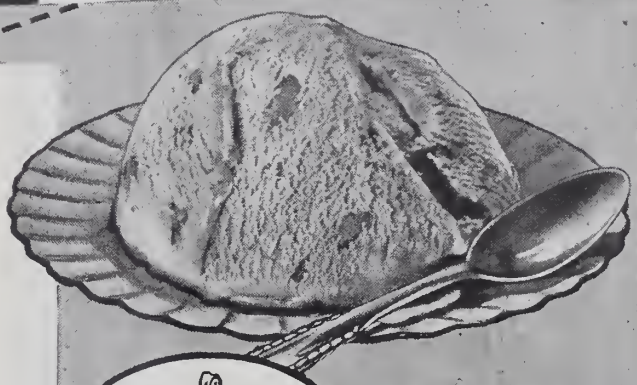
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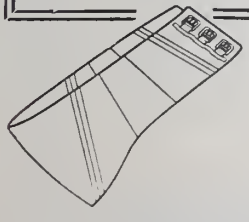


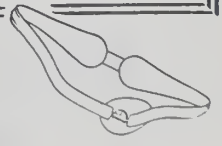
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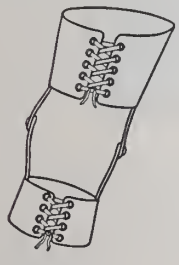




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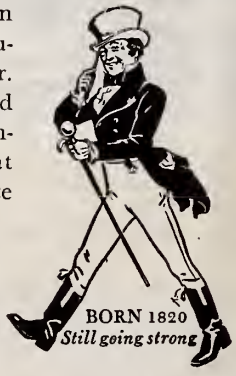
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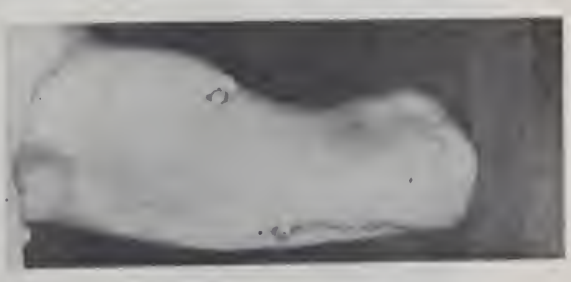
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3. **ELIGIBILITY — See Footnote ★**

4. **DEFINITION — See Footnote ★**

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6. **JUDGES — See Footnote ★**

7. **EXPIRATION DATE — See Footnote ★**

8. **PURPOSE OF THE COMPETITION:** To memorialize the heroism and devotion of the medical profession in war and peace. All exhibitors (including prize-winners) shall retain ownership of their pieces. It is understood, however, that the A.P.A.A. shall have reproduction rights and also the privilege, for a period of three years after the close of the contest, of displaying prize-winning objects, at art museums, libraries, county medical societies, medical schools, hospitals, and similar institutions for the purpose of enhancing the public's estimate of the medical profession. The Association shall also have the right to offer institutions such as those mentioned above, the privilege of copying any of the prize-winning objects for use as murals, cornerstones, friezes, architectural designs, etc. — for the purpose of memorializing the medical profession's importance in war and in peace.

★ **FURTHER INFORMATION** available on request of the Association's Secretary, Dr. F. H. Redewill, Flood Bldg., San Francisco, Cal., or Mead Johnson & Co., Evansville 21, Ind., U.S.A.

PATRIOTIC ANNUAL MEETING—See Page 129

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Roster of Officers and Committees, Advertising Pages 3A-7A

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**Sickness Benefits** —Full monthly benefit for total disability commencing with Eighth day of Disability, limit 12 months, house confinement not required.

**Arbitration Clause** —The Committee on Medical Defense and Insurance of The Medical Society of New Jersey are the SOLE arbiters in the event of any claim disagreement between Company and policyholder.

**Cancellation Clause** —The policy will become non-cancellable on a group basis in any County Society as soon as 50% of the members in such Society are insured with a minimum of fifty lives. (BERGEN, BURLINGTON, CUMBERLAND, ESSEX, GLOUCESTER, PASSAIC, AND UNION COUNTY MEDICAL SOCIETIES HAVE SO QUALIFIED.)

### PREMIUM RATES

(Applicable to ages at entry and attained at annual renewal of insurance)
Ages shown below signify next birthday.

| Monthly Benefits | Dismemberment Benefits | ANNUAL RATES* Ages up to 50 | Ages 51 to 60 | Ages 61 to 65 |
|---|---|---|---|---|
| $100.00 | $ 5000. | $29.50 | $34.00 | $43.00 |
| 150.00 | 7500. | 43.60 | 50.35 | 63.85 |
| 200.00 | 10000. | 57.70 | 66.70 | 84.70 |
| 300.00 | 10000. | 84.90 | 98.40 | 125.40 |

*Premiums may be paid half-yearly or quarterly, pro-rata.
*All rates above INCLUDE $1000 Accidental Death Benefit. Additional Accidental Death Benefit up to $4000 (making a total of $5000) may be procured for an additional annual premium of $1.30 per $1000.

Coverage for hospitalization and nursing fees is available at a small additional premium.

This Company has been in business fifty years and is one of the leading writers of Accident and Health Insurance, with a surplus to policy holders of more than three million dollars.

If you are not now insured under this plan or if you want further information, communicate with the undersigned managers.

**Issued Exclusively by**

**NATIONAL CASUALTY COMPANY**

**Through**

**E. and W. BLANKSTEEN, Mgrs.**

**Authorized Disability Insurance Representatives of The Medical Society of New Jersey**

**76 MONTGOMERY STREET JERSEY CITY 2, N. J.**

**BErgen 4-6051**

# THE MEDICAL SOCIETY OF NEW JERSEY

**Founded July 23, 1766**

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**MEDICAL-SURGICAL PLAN OF NEW JERSEY**
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Available only through prescription pharmacies in bottles of 12 fluid ounces. *The Maltine Company*, New York. Established 1875.

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It didn't take Mary long to decide what to do when Jimmy fell from his coaster wagon. A bruised knee, a frightened, crying child caused her no alarm. Whenever anything went wrong at Mary's house it was always Doctor Moore who was called. Somehow or other he always had the solution to the problem. How fortunate, then, that Jimmy's accident occurred near Doctor Moore's office. And how natural that her first thought should be of him. Hers was a confidence born of experience.

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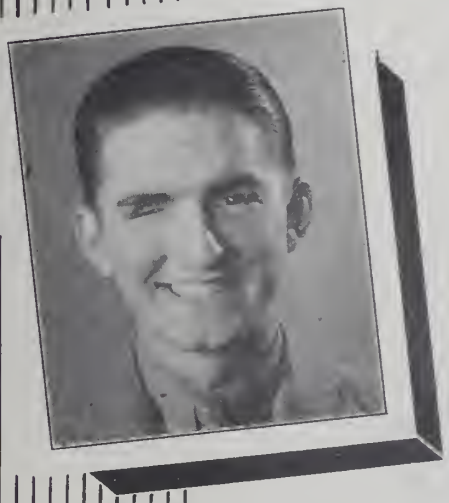

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In conditions of faulty body mechanics, the nonuse of the abdominal muscles allows the pelvis to rotate downward and forward, bringing the sacrum up and back. There results an increased forward lumbar curve with the articular facets of the lumbar spine crowded together in the back. The dorsal spine curves backward with compression of the dorsal intervertebral discs and the cervical spine curves forward with the articular facets in this region closer together. Therefore, chronic strain of the muscles, ligaments and joints of the spine and pelvis occurs.

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# *Penicillin* DOSAGE TABLE*

| INDICATIONS | INITIAL DOSE (UNITS) | CONTINUING DOSAGE (UNITS) | UNITS IN 24 HR. | REMARKS |
|---|---|---|---|---|
| ***Serious Infections*** (staphylococcus, clostridium, hemolytic streptococcus, anaerobic streptococcus, pneumococcus, gonococcus, anthrax, meningococcus)<br>Adults and children | 15,000 to 20,000 | (a) Intravenous drip: 2000 to 5000 every hr. | 40,000 to 120,000 or more | (a) Dissolve ½ of 24 hr. dose in 1 liter (1000 cc.) normal saline; let drip at 30 to 40 drops per minute. |
| | | or<br>(b) Intramuscularly: 10,000 to 20,000 every 3 or 4 hr. | 40,000 to 120,000 or more | (b) Concentration: 5000 U. per cc. normal saline. |
| | | or<br>(c) Intramuscular drip | 40,000 to 120,000 or more | (c) Total daily dose in 250 cc. normal saline. |
| Infants | 5000 to 10,000 | 3000 to 10,000 intramuscularly every 3 hr. | 20,000 to 40,000 or more | Each dose in 1 or 2 cc. of normal saline. |
| ***Chronically infected*** compound injuries, osteomyelitis, etc.<br>Adults and children | 5000 to 10,000 | 10,000 every 2 hr. or 20,000 every 4 hr. intramuscularly or intravenously. Larger doses may be necessary at times. | 40,000 to 120,000 or more | Concentration for intramuscular inj.: 5000 U. per cc. normal saline.<br>For intravenous inj.: 1000 to 5000 U. per cc.<br>Supplement with local treatment. |
| ***Sulfonamide Resistant Gonorrhea*** | 20,000 every 3 hr. intramuscularly for 5 doses | | 100,000 | Results of treatment should be controlled by culture of exudate. |
| ***Empyema***<br>Adults and children | 30,000 to 40,000 once or twice daily into empyema cavity | | 30,000 to 80,000 | Dissolve in 20 to 40 cc. normal saline and inject into empyema cavity after aspiration of pus. |
| ***Meningitis***<br>Adults and children | 10,000 once or twice daily into subarachnoid space or intracisternally | | 10,000 to 20,000 | Concentration: 1000 U. per cc. normal saline. |
| ***Bacterial Endocarditis***<br>Adults and children | 25,000 to 40,000 | 25,000 to 40,000 every 3 hr. intramuscularly | 200,000 to 300,000 | Continuous treatment for 3 weeks or longer. In a few cases the intravenous drip is more advantageous. |

*Based upon recommendations by Chester S. Keefer, *War Production Board Penicillin Leaflet*, Apr. 1, 1945; and by Wallace E. Herrell and Roger L. J. Kennedy, *Journal of Pediatrics*, 25:505, Dec., 1944.

● *Write for pocket size copies of this Dosage Table*

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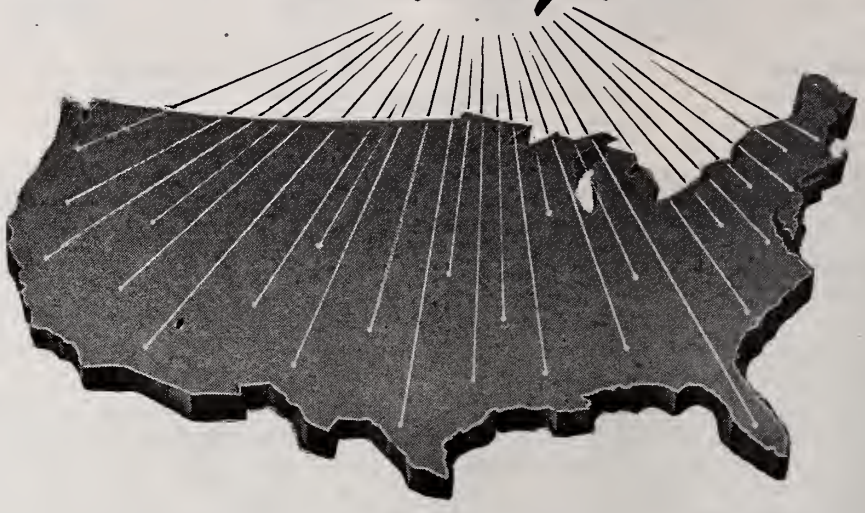
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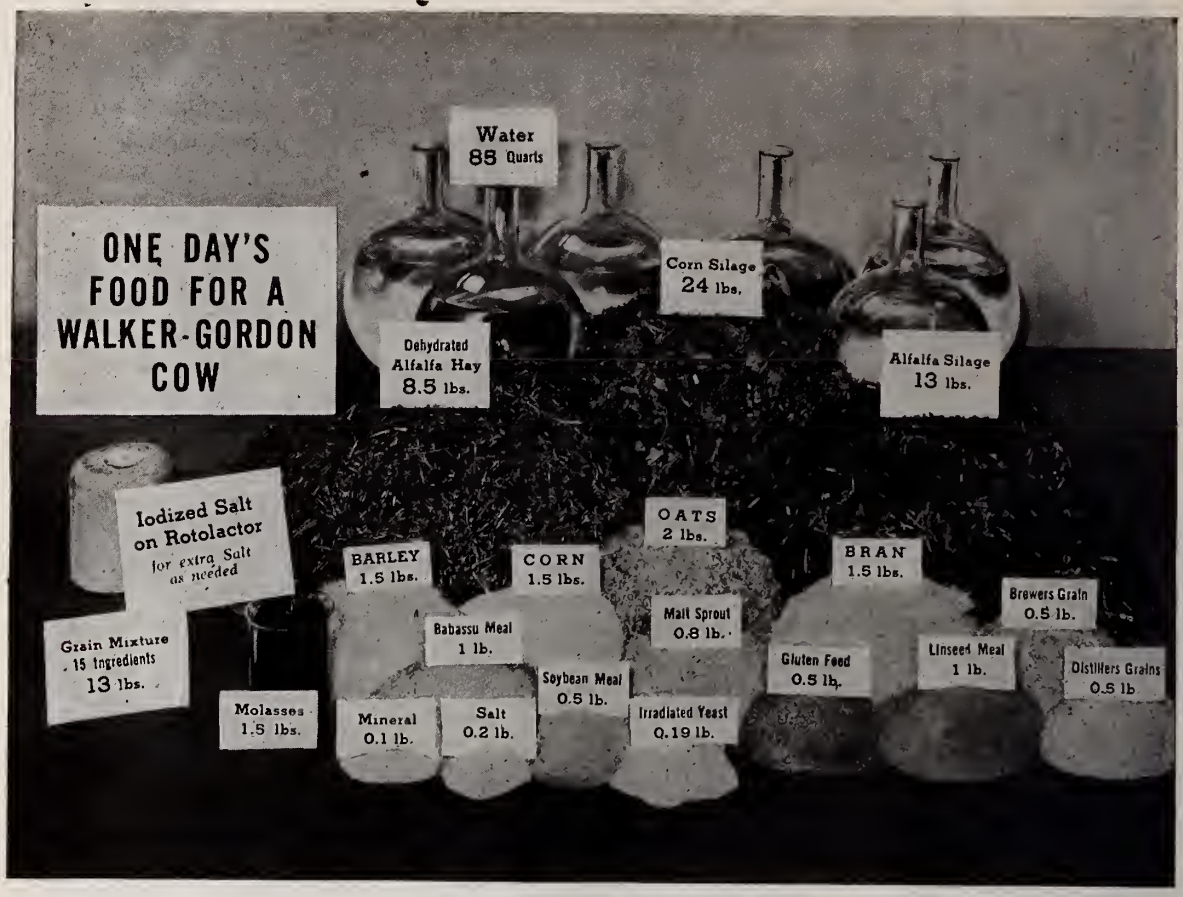





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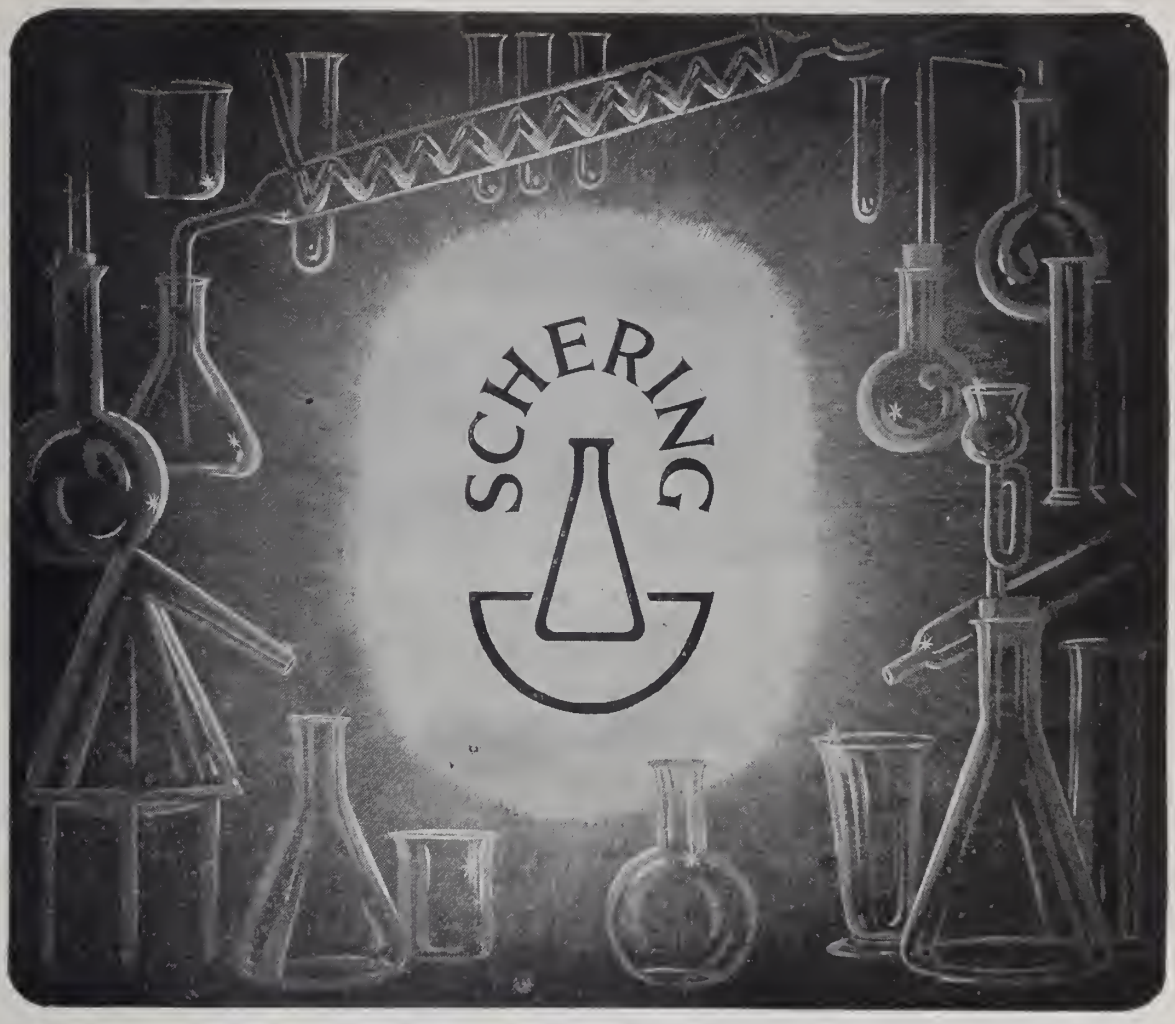
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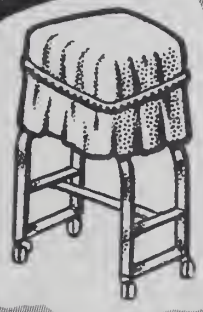
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# ESTROGENIC SUBSTANCE IN OIL

CHEPLIN purified preparation of naturally-occurring estrogenic substance is physiologically standardized, and its potency expressed in terms of international units—assuring definite uniformity of action. ESTROGENIC SUBSTANCE is isolated from pregnant mare urine and contains principally estrone and estradiol in sesame oil. Indicated in menopausal symptoms and sequelae as pruritis vulvae, senile vaginitis and kraurosis vulvae—also in gonorrheal vaginitis. *Literature on request.*

*ESTROGENIC SUBSTANCE IN OIL for intramuscular use supplied in:*

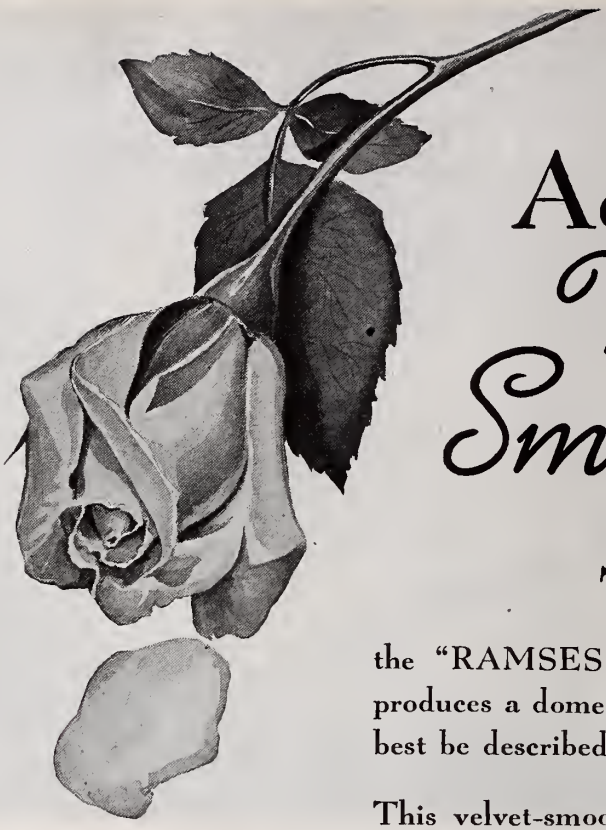
2000 Int. Units per cc.
5000 Int. Units per cc.
10,000 Int. Units per cc.
20,000 Int. Units per cc.

*Each strength is respectively furnished in:*

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# Accent on *Velvet Smoothness*

The process used in manufacturing the "RAMSES"* Flexible Cushioned Diaphragm produces a dome which is soft and pliable and can best be described as being as smooth as velvet.

This velvet-smoothness lessens the possibility of irritation during use.

The "RAMSES" Flexible Cushioned Diaphragm is manufactured in sizes of 50 to 95 millimeters in gradations of 5 millimeters. It is available on the order or prescription of the physician through any recognized pharmacy.




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FLEXIBLE CUSHIONED
DIAPHRAGM

*The word "RAMSES" is the registered trademark of Julius Schmid, Inc.

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**JULIUS SCHMID, INC.**

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# IS SODA-BICARBONATE NECESSARY IN SALICYLATE THERAPY

ACCEPTED AMERICAN MEDICAL ASSN Council on Pharmacy and Chemistry

RARE CHEMICALS

To be effective, the treatment of acute rheumatic fever must maintain a high salicylate level in the blood.[1] When massive doses of sodium salicylate are given by mouth, an undesirable side effect—gastric distress—is frequently encountered. To relieve this effect, equal amounts of sodium bicarbonate are given. Unfortunately, a decided depression of the blood salicylate level results.[2]

Gastric distress and its required relief by sodium bicarbonate are avoided when Salysal is given, for Salysal is not soluble in the acid medium of the stomach. Furthermore, 100 parts of Salysal provide 124 equivalent parts of sodium salicylate.[3] Thus, smaller doses accomplish the same effect.

*Literature and sample on request*




Tablets, 5 grains, bottles of 50, 250, 1000
Powder, 1 oz. bottles

# SALYSAL

The Salicylic Ester of Salicylic Acid

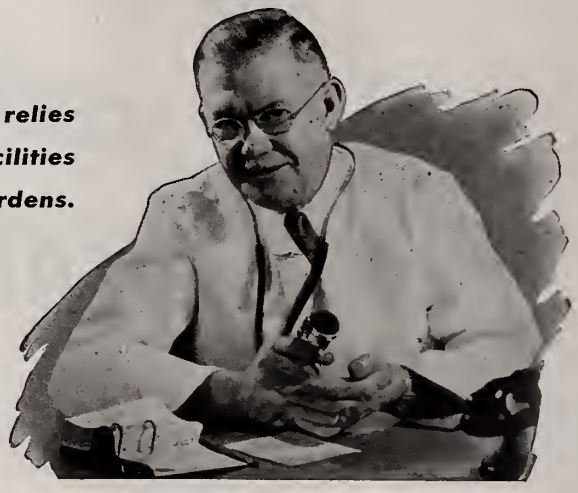
**FOR A TRULY POWERFUL SALICYLATE THERAPY**


1. Coburn, A. F. Salicylate Therapy in Rheumatic Fever, Bull. Johns Hopkins Hosp. 73: 435-464 (Dec.) 1943
2. Smull, K., Wégria, R., and Leland, J. The Effect of Sodium Bicarbonate on the Serum Salicylate Level, J.A.M.A. 125: 1173 (Aug. 26) 1944
3. New and Nonofficial Remedies, 1943, p. 57


RARE CHEMICALS, INC., HARRISON, NEW JERSEY

# "An extra hand of proven skill"

*..says the practitioner who relies upon the Spa's superb facilities for relief from wartime burdens.*



SARATOGA SPA extends to the harassed physician a helping hand of proven skill to lighten his wartime load.

Serving as an old friend in time of need, it provides the facilities for continuing the treatment of patients suffering from such conditions as cardiac, vascular or rheumatic disorders of a chronic nature.

It is a restorative haven in a troubled world for your patient, and a time-tested adjuvant to which you can turn with full confidence.

For professional publications of The Spa, and physician's sample carton of the bottled waters, with their analyses, please write W. S. McClellan, M.D., Medical Director, Saratoga Spa, 159 Saratoga Springs, N. Y.

**SARATOGA SPA**

THE EMPIRE STATE'S CONTRIBUTION TO THE MEDICAL PROFESSION

# *Physicians know from clinical experience*

*the reliability of*

## Pil. Digitalis

*(Davies, Rose)*




**They conform now,**
**as in the past,**
**with U.S.P. requirements**

Each pill is equivalent to 1 U.S.P.XII Digitalis Unit. "One United States Pharmacopoeial Digitalis Unit represents the potency of 0.1 Gm. of the U.S.P. Digitalis Reference Standard."—U.S.P.XII.

Made from Powdered Digitalis Leaf, PIL. DIGITALIS (*Davies, Rose*) present all of the therapeutic principles obtainable from the drug.

Standardized according to Pharmacopoeial requirements, they permit a uniform and accurate dosage.

These freshly prepared, standardized pills are put up in bottles of 35, forming a convenient package for the physician's prescription, obviating the necessity of rehandling.

*Sample for clinical trial sent on request.*

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BOSTON, MASSACHUSETTS, U.S.A.

D19

# A RED CROSS NURSE WRITES:

I'm glad to have my Bamberger friend to turn to...

*And of course her "Bamberger Friend" is the Jean Lambert Dale Shopping Service. Through the months of her overseas service, we've filled her orders for books and food, for recreational equipment for her patients, gifts for her friends at home. We're proud to have been of service to her, and to thousands like her all over the world. We're proud that people feel "One of America's Great Stores" is a friendly store.*

*Now and in the future, we intend to continue our policy of consistently giving high quality service and value . . . the policy that has won us such an enviable reputation.*

L. BAMBERGER & CO.

"ONE OF AMERICA'S GREAT STORES"

*"One of America's Great Stores"*



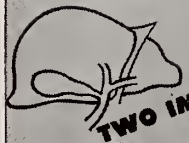

# "AN AMPUL OF PREVENTION...

— is worth a pound of cure" . . . Pastoperative abdaminal distention and urinary retention — and the troublesome procedures that follow — are aften entirely prevented by the rautine use af Prastigmin Methylsulfate 1:4000. Canvalescence may be hastened — "gas pains" and the discamfarts af catheterizatian can be eliminated by this simple, effective treatment. Inject 1 cc af Prastigmin Methylsulfate 'Rache' 1:4000 at the time of operation and continue with five similar injections at 2-hour intervals after the operation . . . . HOFFMANN-LA ROCHE, INC., ROCHE PARK, NUTLEY 10, NEW JERSEY.

*PROSTIGMIN METHYLSULFATE 'ROCHE' 1:4000*




TWO IMPORTANT CONSIDERATIONS IN STEPPING UP BILIARY FLOW



Cholan-DH (chemically pure dehydrocholic acid) has been clinically established as highly efficacious in provoking marked hydrocholeresis. In contrast to older measures which merely clear the gallbladder of its concentrated contents, or step up the flow without either reducing viscosity or relieving gallbladder stasis—Cholan-DH increases water content...reduces viscosity... decreases per cc. the content of cholates and non-volatile solids.

Physicians now employing Cholan-DH find it to be the most potent and least toxic medication ever developed for effective non-surgical management of hepato-biliary disease.

# CHOLAN-DH

THE MALTBIE CHEMICAL COMPANY, NEWARK, NEW JERSEY

AVAILABLE: In bottles of 100 tablets (3¾ gr. ea.)



# "you certainly 'measure-up', young lady"

The physician prescribing Biolac is certain of this... the nutrition of his Biolac Babies "measures-up" to optimum standards.

For Biolac (supplemented with vitamin C) is a *complete* infant formula. Adequate vitamins A, $B_1$, $B_2$ and D, as well as iron and carbohydrate eliminate calculating extra formula ingredients. The high-protein level of Biolac provides for normal growth and optimum health. Because of the scientifically adjusted milk-fat content, Biolac is readily assimilated—with a minimum of fat upsets. Small, soft curds and ample lactose assure ease of digestion and a natural stool closely resembling that from human milk.

BORDEN'S PRESCRIPTION PRODUCTS DIVISION
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*Easily calculated... quickly prepared. 1 fl. oz. Biolac to 1½ fl. oz. water per pound of body weight.*

*Biolac is a liquid modified milk, prepared from whole and skim milks, with added lactose, and fortified with vitamin $B_1$, concentrate of vitamins A and D from cod liver oil, and ferrous citrate. Evaporated, homogenized and sterilized. Vitamin C supplementation only is necessary. Available in 13 fl. oz. cans at all drug stores.*

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# Biolac—"BABY TALK" FOR A GOOD SQUARE MEAL

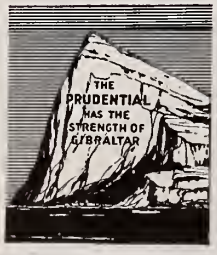
# To the Cause of Humanity

**The Physician thus dedicates his wisdom and skill.**

**In this great effort to alleviate pain and eliminate disease, the doctor often is so engrossed in his work that he forgets one most important duty he owes to himself. That is the security of his dependents and his own advanced years.**

**Another servant of humanity stands ready to protect him.**

**It is Life Insurance.**




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INSURANCE COMPANY OF AMERICA
*A mutual life insurance company*
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# A NOTABLE PRODUCTION ACHIEVEMENT




*Copies of this up-to-date chart, containing the essentials of Penicillin therapy, are available on request.*




THE record performance of Penicillin manufacturers in achieving large-scale production has resulted in the fulfillment of current military requirements for this remarkable antibacterial agent. Penicillin Sodium Merck now is available to the medical profession for the treatment of civilian patients, having heen released hy the War Production Board for general distribution through customary supply charnels.

In this notable production achievement, Merck & Co., Inc. has been privileged to play a pioneering and progressively important rôle. Basic discoveries made by Merck microbiologists, and shared with other Penicillin producers, contributed vastly to the successful development of Penicillin manufacture. By applying chemical engineering technics to the manufacture of this difficultly produced antibiotic agent, Merck independently succeeded in devising and perfecting a practical method of large-scale production hased on the mass-fermentation principle.

Penicillin Sodium Merck meets the recognized high standard of quality established for all products bearing the Merck label.

MERCK

**PENICILLIN**
MERCK

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Council Accepted

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Speed the Victory with War Bonds

MERCK & CO., Inc. *Manufacturing Chemists* RAHWAY, N. J.

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## *The World's Finest*

## THERAPEUTIC EQUIPMENT

The Hanovia Chemical and Manufacturing Co. is recognized the world over as the largest producers of ultraviolet equipment for hospitals, the medical profession, the laboratory and the home. It is well to remember that in the purchase of therapeutic equipment, the name HANOVIA on the unit you buy, is your guarantee and assurance of complete satisfaction.



**HANOVIA AERO-KROMAYER LAMP AIR-COOLED**

**A Wide Range of Clinical Usefulness**

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**Two Important Ultraviolet Lamps for your Therapeutic practice**



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## HANOVIA Chemical & Mfg. Co.

*World's largest manufacturers of ultraviolet equipment for the medical profession.*

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# S·I·M·I·L·A·C

*Similar to human milk*




**★The name is never abbreviated; and the product is not like any other infant food—notwithstanding a confusing similarity of names.**

The fat of Similac has a physical and chemical composition that permits a fat retention comparable to that of breast milk fat (Holt, Tidwell & Kirk, Acta Pediatrica, Vol. XVI, 1933) . . . In Similac the proteins are rendered soluble to a point approximating the soluble proteins in human milk . . . Similac, like breast milk, has a consistently ZERO curd tension . . . The salt balance of Similac is strikingly like that of human milk (C. W. Martin, M. D., New York State Journal of Medicine, Sept. 1, 1932). *No other substitute resembles breast milk in all of these respects.*

ACCEPTED AMERICAN MEDICAL ASSN.

A powdered, modified milk product especially prepared for infant feeding, made from tuberculin tested cow's milk (casein modified) from which part of the butter fat is removed and to which has been added lactose, olive oil, cocoanut oil, corn oil and fish liver oil concentrate.

**SIMILAC } SIMILAR TO HUMAN MILK**

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*. . may I suggest you*
*buy more*
*U. S. War Bonds today?*

J. W. Harper




it's always a pleasure

# I. W. HARPER

since 1872

the gold medal whiskey

**Distilled in peace time and Bottled in Bond under the supervision of the U. S. Government.**

Kentucky Straight Bourbon Whiskey, Bottled in Bond, 100 Proof, Bernheim Distilling Co., Inc., Louisville, Kentucky.




## *Each week baby's weight goes up*

He gains well and is happy on a Dexin-rich formula. The high dextrin content of 'Dexin' provides a relatively low fermentable form of carbohydrate so that weight-losing distention, colic and diarrhea are minimized. Milk curds are made soft, flocculent and easily digested.

Mother, with a well baby, has more time for herself, since Dexin is so easy to prepare — being readily soluble in either hot or cold milk.

'Dexin' Registered Trademark

*Literature on request*




*'Dexin' does make a difference*

COMPOSITION

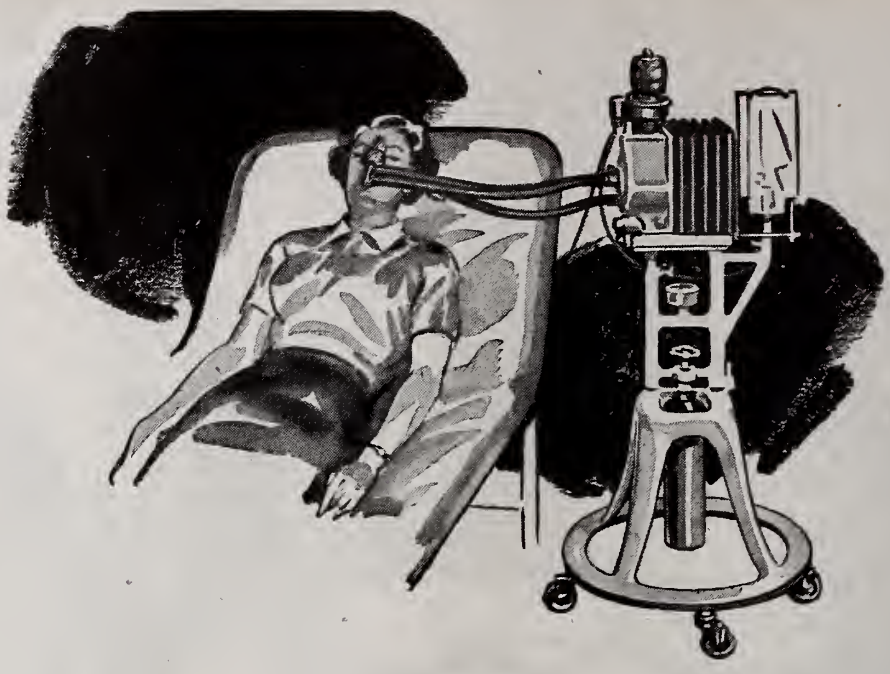
| | |
|---|---|
| Dextrins | 75% |
| Maltose | 24% |
| Mineral Ash | 0.25% |
| Moisture | 0.75% |

Available carbohydrate 99%
115 calories per ounce
6 level packed tablespoonfuls equal 1 ounce
Containers of 12 oz. and 3 lbs.

# 'DEXIN'

HIGH DEXTRIN CARBOHYDRATE

BURROUGHS WELLCOME & CO. (U. S. A.) INC., 9-11 East 41st Street, New York 17, N. Y.



# *In Hyperthyreosis, too*

The symptom complex of increased appetite, exaggerated psychomotor tension, hyperhidrosis, and loss of weight, in addition to spelling thyrotoxicosis, also reflects the intense metabolic activity characteristic of this condition. Utilization of nutrients may be 50 per cent above normal.

Whether therapy be conservative or surgical, metabolic deficits must be eradicated and some of the consumed body tissue restored. To this end the intake of virtually all essential nutrients must be doubled. If surgery is contemplated, nutritional preparation ranks in importance with iodine preparation for a successful outcome.

Ovaltine can be a valuable component of the high-caloric, high-vitamin diet required in hyperthyreosis. This delicious food drink, made with milk, not only increases the caloric intake appreciably, but also significantly augments the intake of complete proteins and of vitamins and minerals, all of which are required in added amounts.

**THE WANDER COMPANY, 360 N. MICHIGAN AVE., CHICAGO 1, ILL.**




*Ovaltine*

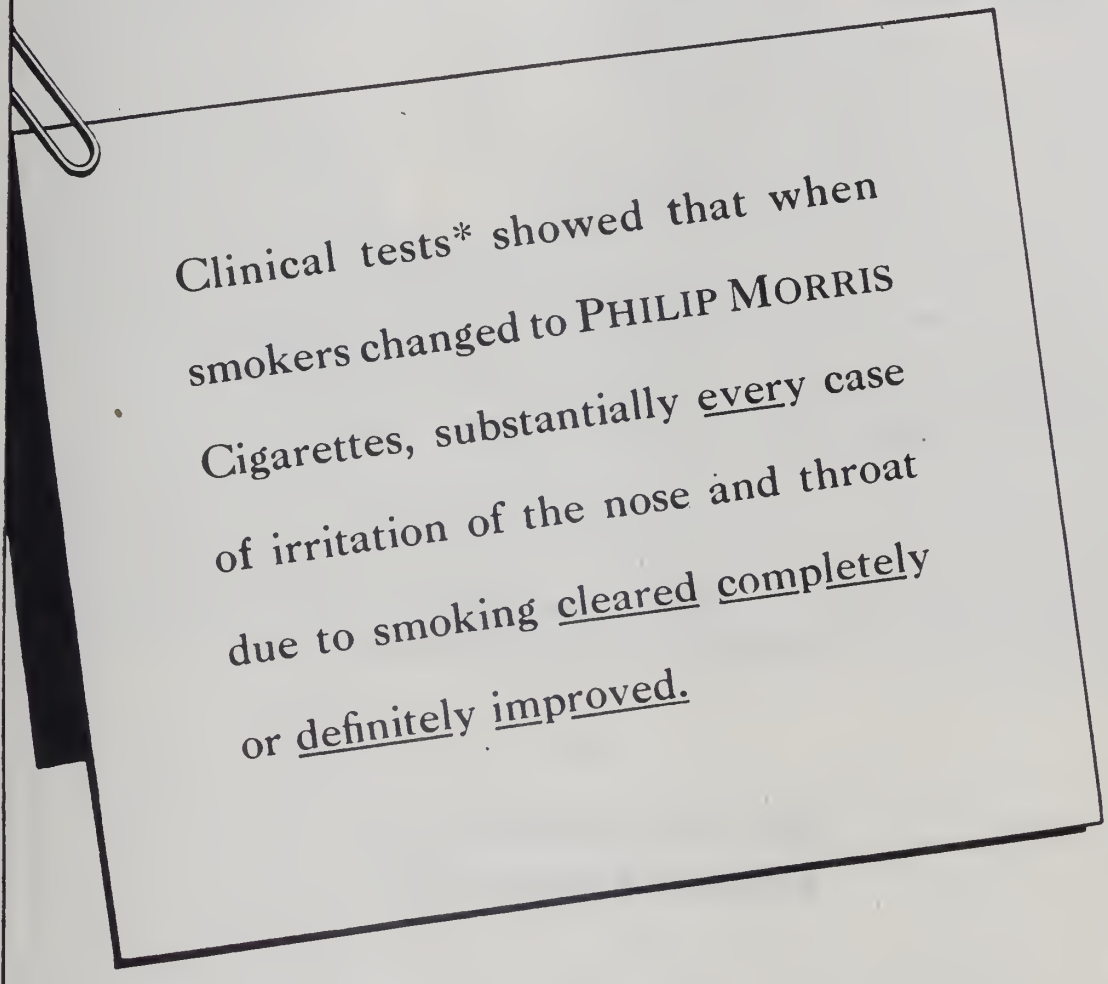
Three daily servings of Ovaltine, each made of ½ oz. Ovaltine and 8 oz. of whole milk,* provide:

| | | | |
|---|---|---|---|
| PROTEIN | 31.2 Gm. | VITAMIN A | 2953 I.U. |
| CARBOHYDRATE | 62.43 Gm. | VITAMIN D | 480 I.U. |
| FAT | 29.34 Gm. | THIAMINE | 1.296 mg. |
| CALCIUM | 1.104 Gm. | RIBOFLAVIN | 1.278 mg. |
| PHOSPHORUS | .993 Gm. | NIACIN | 7.0 mg. |
| IRON | 11.94 mg. | COPPER | .5 mg. |

*Based on average reported values for milk.

# 29 WORDS

## tell the story...




*Laryngoscope, Feb. 1935, Vol. XLV, No. 2—149-154.

TO THE PHYSICIAN WHO SMOKES A PIPE: We suggest an unusually fine new blend—COUNTRY DOCTOR PIPE MIXTURE. Made by the same process as used in the manufacture of Philip Morris Cigarettes.

# Belle Mead Sanatorium

**Belle Mead** **New Jersey**

*Under State License Since 1910*

**Sanatorium Phone**
**BELLE MEAD, N. J. 21**

● **For the individual care and modern treatment of nervous, mental, alcoholic, drug patients and general invalidism.**

●

**Full Cooperation**
**With Referring Physicians**

●

**Rates Very Reasonable for**
**Attractive Accommodations**

●

J. C. Kindred, M.D., *Consultant*

L. R. Harrison, M.D., *Consultant*

Mason Pitman, M.D. Russell N. Carrier, M.D.*

*Medical Directors* * Military Service




When patients are subjected "to some physiologic strain, a febrile illness, hyperthyroidism, a period of unusual exertion, an attack of diarrhea, an operation, or perhaps mere curtailment of food intake, then nutritive failure is precipitated and evidences of ill health appear."[1]

Vitamin reserves may be too meager to withstand increased metabolism or decreased ingestion. One way to spare patients the added debilitating effects of nutritive failure is to prescribe Upjohn vitamin preparations.

# UPJOHN VITAMINS

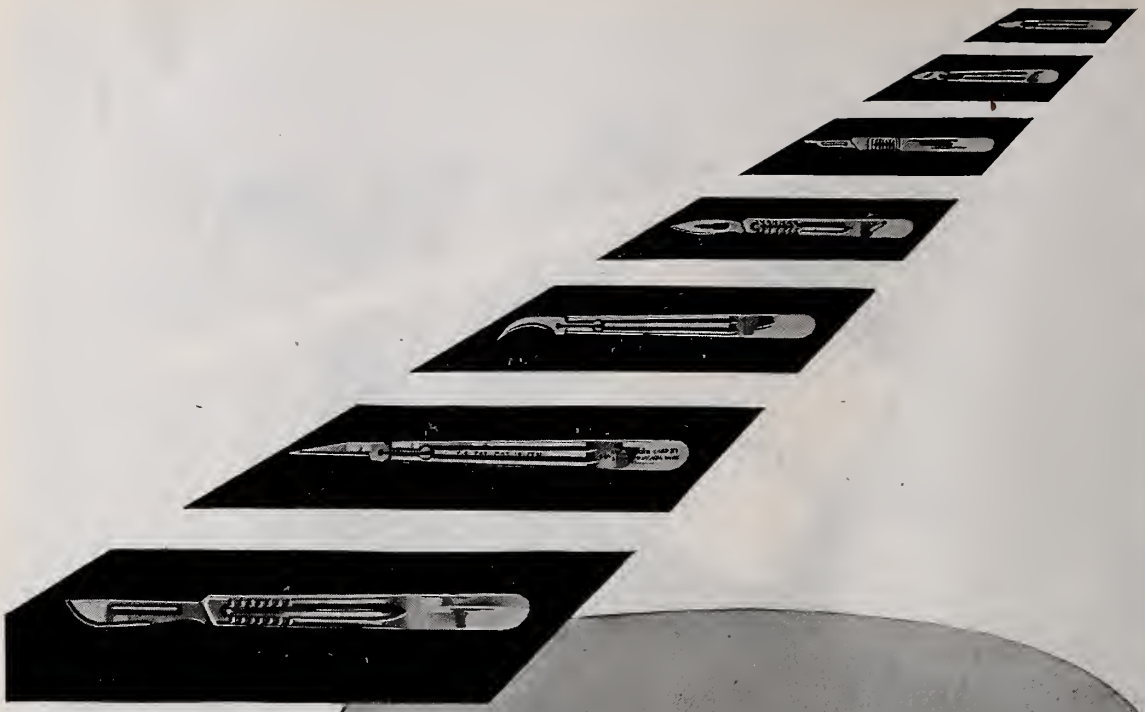
ARMY (E) NAVY

Upjohn

KALAMAZOO 99, MICHIGAN

1. Bull. N. Y. Acad. Med. 13:497 (Aug.) 1942.

DO MORE THAN BEFORE — KEEP ON BUYING WAR BONDS



## SELECT YOUR SULFONAMIDES AS YOU WOULD A SCALPEL

It is axiomatic that good surgery requires good tools—tools that fit the job at hand. It is no less important to select the proper sulfonamide in an appropriate dosage form to meet and deal most effectively with specific infections.

Sulfonamides, Lilly, for systemic and local administration, are provided in a complete variety of dosage forms for every indication. They are quickly available through the drug trade.

Lilly

Eli Lilly and Company, Indianapolis 6, Indiana, U. S. A.

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Volume 42
Number 5



# THE JOURNAL
## OF
# THE MEDICAL SOCIETY OF NEW JERSEY

Published Monthly Since September, 1904
Whole Number of Issues, 489

Under the
Direction of the
Committee on Publication

Henry C. Barkhorn, M.D., Chairman

Henry A. Davidson, M.D., Editor
In Active Service A. U. S.

**Place of Publication, Printing and Mailing—12 South Day Street, Orange, N. J.**
**Editorial and Executive Offices of the Society—315 West State Street, Trenton 8, N. J.; Tel. 5776**
Each member of the State Society is entitled to receive a copy of The Journal every month.

Vol. 42, No. 5 May, 1945 Subscriptions, $3.00 per Year
Single Copies, 30 Cents

## EDITORIAL

### 1945 ANNUAL MEETING

In view of the interdiction placed upon travel by the O.D.T. it is now thought to be impossible to have a meeting of the House of Delegates or any meeting of any group of the State Society in excess of fifty. In order that the functions of the State Society shall proceed smoothly, and that the incoming administration shall have ample time in which to organize its activities for the coming year, the program outlined in the following resolution was adopted by the Board of Trustees on Sunday, April 15, 1945, as the most feasible.

The Board of Trustees will meet at the Hotel Claridge in Atlantic City on the evening of May 22nd and during the day of May 23rd.

The members of the Nominating Committee of the State Society will meet on the evening of May 22nd at 8:00 p. m. at the Hotel Claridge. The report of the Nominating Committee will be received by the Board of Trustees on May 23rd.

Each County Society is requested to adequately discuss with its Nominating Delegate the importance of this meeting and direct him to attend.

At the completion of the deliberations of the Board of Trustees on May 23rd a copy of its findings will be forwarded to each County Society for ratification.

Legal opinion has been obtained from the State Society's counsel, who states:

> "There is no doubt of the Trustees' power to act. The generality of the language in Chapter VI, Section 5 (b) of the By-Laws confers the power, and when one considers the reason which lies behind the restriction imposed by the War Committee on Conventions, it is plain that you have every power except to hold a meeting in excess of the numbers that the restriction permits."

Application to the War Convention Committee for permission to hold a one-day meeting of the House of Delegates May 23rd has been denied.

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## ANNUAL MEETING — ACADEMY OF MEDICINE

**Thursday, May 17, 1945**

**AT 8:45 P. M.**

I. Regular Business of the Academy

II. Election of Fellows and Officers

III. Remarks by the Retiring President

IV. Presentation of the Edward J. Ill Award to Edward Wharton Sprague, M.D.
Citation—Henry C. Barkhorn, M.D.
Presentation—Royal A. Schaaf, M.D.
Response—Edward W. Sprague, M.D.

V. ADDRESS: "Oh Why Should the Spirit of Mortal Be Proud?"
Harrison S. Martland, M.D., Chief Medical Examiner, Essex County; Professor of Forensic Medicine, New York University School of Medicine; Pathologist, Newark City Hospital.

*Bring your family and friends.*

# ANNUAL REPORTS

## PRESIDENT-ELECT

Samuel Alexander, M.D., Park Ridge

The coming year brings problems of exceeding importance, affecting the health and well-being of the people of this State. It is most essential that the public be kept properly informed concerning the matters so vital to them. To accomplish this purpose the activities of the Welfare Committee become of paramount importance.

### PUBLIC RELATIONS

During the past year it has become very apparent that many groups and individuals are taking a keen interest in the problem of adequate medical care for our people. These people want information. It is our duty to see that the great majority of people become properly acquainted with our viewpoint in order to understand how serious this problem really is, and what is being done to meet it. They do not realize that we have a very definite plan to meet medical needs for various wage scale groups. Unless a definite program is set up to present our viewpoint great harm may be done to the practice of medicine as we know it.

An enlightened public opinion is the greatest safeguard to offset the many visionary plans suggested by those who think they can legislate medical care of the highest type into the lives of our people.

### LEGISLATION

There never was a time when close watch on legislation at Washington and Trenton was more necessary than at present. We have always supported proposed legislation affecting public health of a constructive nature in both legislative halls. However, many bills are being introduced in the Congress of the United States which affect directly and indirectly the very existence of the practice of medicine as it is at present. At Trenton bills are introduced annually which would, if passed, allow men with sub-standard professional qualifications to practice medicine. It might be of interest to know that about 10 per cent of all measures introduced have health implications.

The welfare of the public must be our first consideration. Only by eternal vigilance can the public be protected against the harm that might befall them by obnoxious legislation, either in Trenton or in Washington.

### MEDICAL SERVICE ADMINISTRATION AND MEDICAL-SURGICAL PLAN

These agencies must continue to have the wholehearted support of our members. They are in a large way our answer to those who would take over the medical care of our people.

These programs have been handled efficiently and successfully, and as they are emerging from the experimental stage large groups are showing a keen interest in these plans.

### MEDICAL PRACTICE

Members of our Society in the Armed Forces are anxious to return to private practice as soon as they are released from military service. Many seem concerned about what type of medical practice they will have on their return. It is the obligation of those of us in civilian life to do everything that can be done to assist in reëstablishing them in the kind of practice they desire on their return.

There are other problems which we must face, but I am confident that with time and study, solutions can be worked out for them.

## SECRETARY

Alfred Stahl, M.D., Newark

Statistical report on the Official List of Members of The Medical Society of New Jersey, as of March 1, 1945:

| | |
|---|---|
| **Paid-up Members, 1945** | |
| Active | 4,244 |
| Associate | 84 |
| **Members in Service, 1945** | |
| Active | 1,444 |
| Associate | 26 |
| Members Deceased, March 1944-March 1945 | 50 |
| Transfers, March 1944-March 1945 | |
| In from Other States | 14 |
| Out to Other States | 10 |
| Within State | 4 |
| Resignations, March 1944-March 1945 | 5 |
| New and Reinstated Members | 104 |
| Delinquents (Members in 1944, not paid in 1945) | 146 |

## TREASURER

GEORGE J. YOUNG, M.D., Morristown

The fiscal year of the Society does not close until May 31, 1945. A complete financial report will be presented directly to the House of Delegates.

## JUDICIAL COUNCILORS

### SECOND DISTRICT

**Sussex, Bergen, Hudson and Passaic Counties**

VINCENT P. BUTLER, M.D., Councilor
Jersey City

Again this year, as in the past several years, the Councilor has no activity to report. This it is hoped is an indication of a healthy state in the ethical relations of the members.

The continued inactivity of the Judicial Council, it seems, calls for some change in its status in the organization of The Medical Society of New Jersey. Perhaps this will evolve in time.

### THIRD DISTRICT

**Mercer, Middlesex, Somerset and Hunterdon Counties**

BARCLAY S. FUHRMANN, M.D., Councilor
Flemington

Your Councilor for the Third District has nothing to report for the year.

### FOURTH DISTRICT

**Camden, Burlington, Ocean and Monmouth Counties**

S. EMLEN STOKES, M.D., Councilor
Moorestown

There have been no problems reported to the Judicial Councilor for the Fourth District calling for action, which indicates prevailing harmony. There has been no need for my services during the year, but I assure the officers and members of each County Society in this district of my interest in their work and willingness to serve them whenever called upon.

### FIFTH DISTRICT

**Atlantic, Cape May, Cumberland, Gloucester and Salem Counties**

CHESTER I. ULMER, M.D., Councilor
Gibbstown

The Councilor for the Fifth District has had no requests for his services during the past year.

## EXECUTIVE AND EDITORIAL OFFICES

EDITH L. MADDEN, Acting Executive Officer, Trenton

The type of work in the Executive and Editorial Offices continues along the same lines as in previous years. The volume varies according to the activities of the Officers and Committees.

The newest addition to the work of the staff has been the preparation, publication and distribution of the Service Physicians News Letter which goes to all our members in service every three months.

Another responsibility has been the supervision of the renovation of the new Permanent Home and the purchase of the necessary equipment.

All requests for material and information have been complied with as quickly as possible.

The arrangements for the various sessions and exhibits of the 1945 Annual Meeting were completed last fall. Upon notification from the War Convention Committee, immediate cancellations were forwarded to all concerned.

The staff of three has worked diligently and sincerely in the interests of the Society and we will continue to give our best efforts to the incoming administration.

# STANDING COMMITTEES

## FINANCE AND BUDGET

Harry R. North, M.D., Chairman, Trenton

The Committee on Finance and Budget has reviewed the expenditures for the current year, and the requested budget appropriations for 1944-45. A tentative budget for the new year has been set up, with the idea of curtailing expenditures as much as possible; certain recommendations will be presented to the Board of Trustees for consideration together with the proposed budget.

A meeting of the Committee will be held after the Trustees have reviewed the recommendations and proposed budget, at which time the final budget for 1945-1946 will be prepared for presentation to the House of Delegates.

## ADVISORY TO THE WOMAN'S AUXILIARY

William E. Dodd, M.D., Chairman, Beach Haven

In a spirit of coöperation with the Federal Government's request to minimize travel during war time, this committee has held no formal meetings this year. Its activities have been conducted by telephone, correspondence, and an occasional conference between its chairman and the President of the Woman's Auxiliary.

Early in the year an attempt was made to bring closer coöperation between the activities of the Woman's Auxiliary and those of The Medical Society of New Jersey. To this end the various Subcommittees of the Welfare Committee were asked to make suggestions as to how the Woman's Auxiliary could best help them with their various problems. A number of suggestions were received and passed on to the Woman's Auxiliary.

The Woman's Auxiliary then formulated the following program of activities for the year, which was approved by this committee:

1. To continue the promotion and distribution of Hygeia magazine.
2. To aid in the advancement of health education.
3. To give its attention to controversial legislative matters such as Emergency Maternal and Infant Care, and the Wagner-Murray-Dingell Bill.
4. To consider post-war problems of Medical Economics.
5. To promote the Medical-Surgical Plan of New Jersey.
6. To participate in recruiting students for the U. S. Cadet Nurse Corps.
7. To promote a reëstablishment program for members of The Medical Society of New Jersey who are returning from military to civilian practice.
8. To aid in the distribution of knowledge concerning "The Society for the Relief of Widows and Orphans of Medical Men of New Jersey".
9. To strive to improve public relations between organized medicine and the laity.

This committee realizes the difficulties confronting the members of the Woman's Auxiliary in carrying forward any program of endeavor under war-time conditions, and extends its congratulations to the loyal members of the Auxiliary who, in spite of these difficulties, are carrying on their worthy projects.

## SCIENTIFIC WORK

William W. Maver, M.D., Chairman, Jersey City

The Scientific Work Committee has no report to make for the year.

# PUBLICATION

HENRY C. BARKHORN, M.D., Chairman, Newark

The work of the Publication Committee has in the past year been much more arduous than in previous years. This was due to war conditions, paper shortage, lack of material presented for publication and many other factors. However, because of the help of Dr. Norman M. Scott, who graciously wrote most of the editorials, Mrs. Edith L. Madden and Mrs. Miriam Nilis Armstrong, we have had our usual successful year.

We again express our thanks to Mr. Roy Hill of the Orange Publishing Company, The Coöperative Medical Advertising Bureau of the American Medical Association, and our advertisers for their loyalty and support.

The coming year, because of the omission of the Scientific Session, will also be difficult. We urge members to submit scientific articles for consideration for publication and we urge County Society officers to coöperate in getting exceptional original papers presented at their meetings for possible publication in our *Journal*.

We recommend the reappointment of Major Henry A. Davidson as Editor (without pay) on leave of absence in service A. U. S.

Following is a short financial statement and a table of distribution by pages:

## RECEIPTS

From June 1, 1944, to March 31, 1945

| | |
|---|---|
| Net cash receipts | $15,848.44 |
| Estimated receipts to May 31, 1945 | 3,500.00 |
| Total | $19,348.44 |

## EXPENSES

From June 1, 1944, to March 31, 1945

| | |
|---|---|
| Journal publication and reprints | $11,497.06 |
| Estimated expenses to May 31, 1945 | 3,300.00 |
| Total | $14,797.06 |

## ADVERTISEMENTS

Included among the advertising pages are those devoted to *Society Organization,* as follows:

| | |
|---|---|
| The index of the reading pages, which appears on the first cover page of each *Journal* | 12 pages |
| The list of officers and committees | 15 pages |
| Total | 27 pages |

## SUPPLEMENTS

| | |
|---|---|
| April, 1944—Official List of Members | 60 pages |
| August, 1944—Official Transactions | 32 pages |
| Total | 92 pages |

| 1944 | Editorials | War News | Medical Service Administration Medical-Surgical Plan | Original Articles | Executive Officer's Page | Legislative News | Timely Topics | State Activities | County Society Reports | Woman's Auxiliary | Bulletin Board | Book Reviews | Total Reading Pages | Pages of Advertising Including Covers | Total Pages in Monthly Issues |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| January | 3 | 2 | | 18 | | | | 3 | 2 | 3 | | 1 | 32 | 36 | 68 |
| February | 4 | | 4 | 8 | | | | 13 | 2 | 4 | | 3 | 38 | 38 | 76 |
| March | 6 | | | 10 | | | | 12 | 5 | 4 | | 3 | 40 | 40 | 80 |
| April | 1 | | | | | | | 59 | | | | | 60 | 80 | 140 |
| May | 4 | | | 20 | | | | 6 | 4 | 4 | | 2 | 40 | 40 | 80 |
| June | 3 | | 2 | 17 | | | | 10 | 4 | 2 | | 2 | 40 | 48 | 88 |
| July | 5 | 2 | | 15 | | | | 6 | 2 | 1 | | 3 | 34 | 42 | 76 |
| August | 3 | | | 14 | | | | 6 | 2 | 1 | | 2 | 28 | 52 | 80 |
| September | 3 | | | 21 | | | | 4 | | 1 | | 1 | 30 | 50 | 80 |
| October | 3 | | 1 | 18 | | | | 5 | 1 | 2 | | 2 | 32 | 52 | 84 |
| November | 2 | | 1 | 10 | | | | 6 | 5 | 4 | | 2 | 30 | 58 | 88 |
| December | 4 | | | 13 | | | | 12 | 4 | 3 | | 2 | 38 | 50 | 88 |
| Totals 1944 | 41 | 4 | 8 | 164 | | | | 142 | 31 | 29 | | 23 | 442 | 586 | 1028 |
| Totals 1943 | 29 | 26 | 19 | 161 | 2 | 12 | | 157 | 19 | 21 | 4 | 26 | 476 | 484 | 960 |
| Totals 1942 | 37 | 56 | | 244 | 4 | 7 | 7 | 181 | 48 | 27 | 13 | 29 | 653 | 467 | 1120 |
| Totals 1941 | 42 | | | 306 | | | | 212 | 53 | 31 | 7 | 23 | 674 | 474 | 1148 |
| Totals 1940 | 46 | | | 241 | | | | 260 | 70 | 11 | | * | 628 | 484 | 1112 |

*In 1940 the Book Reviews were included in State Activities.

## ANNUAL MEETING

Harrold A. Murray, M.D., Chairman, Newark

The cancellation of the 1945 Annual Meeting, scheduled for Atlantic City, May 22-24, was a great disappointment to all. A splendid scientific program had been arranged which would have brought forth the attendance of a great many members. The exhibits were rearranged to the advantage of both the doctors and the exhibitors and all spaces were reserved within six hours after the first reservation was received.

Plans for a substitute business meeting of the House of Delegates have been left to the President and Chairman of the Board of Trustees. The best possible meeting, under present conditions, will be arranged.

The Committee wishes to thank Mrs. Edith Madden and her staff for their usual efficiency in the preparation of the essential details of the meeting, the Section Officers for their splendid coöperation in the arrangement of the scientific programs, the speakers who so willingly accepted our invitations to speak, and the exhibitors who so enthusiastically showed their desire to be with us in New Jersey. We look forward to the return to our usual three-day session and the renewal of friendships among our members, speakers and exhibitors.

## SCIENTIFIC PROGRAM

Thomas McG. Brennock, M.D., Chairman, Jersey City

The Committee regrets the necessity of cancelling the fine scientific programs arranged for the 1945 Annual Meeting and expresses its appreciation to the Section Officers and Speakers for their coöperation. We hope we will be able to follow through with our arrangements next year.

## GRADUATE MEDICAL EDUCATION

Henry B. Decker, M.D., Chairman, Camden

The Committee on Graduate Medical Education met several times during the past year and after discussion submitted, through Dean Miller, the following proposal to Rutgers University:

"The Medical Society of New Jersey, through its Committee on Graduate Medical Education, proposes that Rutgers University establish a Graduate School of Medicine.

"The objective of this school would be the further training of the practicing physician in the general practice of medicine.

"The training plan would utilize the outpatient departments and wards of various hospitals throughout the state.

"The teachers would be selected staff members of the hospitals.

"The course of study would extend over thirty-six months and require attendance at a hospital twice weekly, for from two to three hours.

"Upon submission of an acceptable thesis, the degree of Master of Science in Medicine will be granted.

"The Medical Society of New Jersey will coöperate with Rutgers University in organizing and operating this course.

"The Medical Society of New Jersey feels that the democratic organization of the Graduate School in Rutgers University is ideal for the operation of the proposed Graduate School of Medicine."

At present this proposal is being studied by the authorities of Rutgers University and in due time a report will be made.

## WELFARE

J. Howard Hornberger, M.D., Chairman, Roebling

The Welfare Committee held three meetings during the present administration. They were well attended and the interest of the members in the present and post-war problems was very noteworthy.

The deliberations and recommendations will be well and fully covered in the reports of the various Subcommittees to which you are respectfully referred.

A few of the highlights which we might mention are:

1. Our continued opposition to governmental encroachment on the private practice of medicine both from the standpoint of Federal and State Governments.

2. Our sympathetic understanding of the present and future problems of the returning Veterans with the thought of again making useful American citizens of these men and women who have given so much that our way of life may continue.

3. The endorsement of the National Physicians Committee.

Your Chairman would be very much amiss in his trust if he did not take this opportunity to express his sincere thanks to our President, members of the Executive Staff, Chairmen and members of the various Subcommittees and to the members of the Welfare Committee at large for their efforts in his behalf during this trying year. Any measure of success which may have been achieved is due entirely to their devotion. Thanks.

# SUBCOMMITTEES

## LEGISLATION

L. Samuel Sica, M.D., Chairman, Trenton

This session of the State Legislature has been unusually busy and exacting. After its recess of three weeks the Legislature, upon reconvening March 12th, met two or three times every week.

The bills sponsored by the State Department of Health (S-11, S-12, S-13 and S-14), for the control of venereal diseases, passed both Houses and were signed by the Governor.

Senate Bill 215, which permits a Judge of the Court of Common Pleas to commit recalcitrant tuberculosis patients to an institution, designated by the Department of Institutions and Agencies, until such patients are no longer infectious, passed both Houses of the Legislature. At the date of writing this report this Bill (215) had not been received by the Governor.

This measure, which was actively supported by the Committee on Legislation, was formulated as the result of joint consideration by the Department of Health, the Department of Institutions and Agencies and the Medical Superintendents of the County Tuberculosis Hospitals.

Senate Bill 217, which would have given the Department of Health blanket authority to apply for and to receive available Federal funds for public health purposes, passed the Senate April 6th. On the last day of the session, April 10th, the measure was passed in the Assembly, but shortly thereafter a motion to reconsider passed and the bill was laid over; and was not repassed before final adjournment.

We understand the latter action—reconsideration of the passage of this measure in the Assembly—was made at the request of the Governor. A likely reason for the Governor's action is that Assembly Bill 404 (which will be referred to subsequently), having to do with the reorganization of the State Department of Health, provides that the Commissioner (of Health) may apply for Federal funds for public health purposes "subject to approval by the Governor and the Public Health Council". (The "Public Health Council" in the proposed Act replaces the present "Board of Health".)

While Senate Bill 180, introduced by Senator Stanger, to create a separate board of chiropractic examiners, was the cause of sud-

den concern and some trouble the last week before adjournment the measure was never reported and hence never came to a vote.

Assembly Bill 380, introduced by Mr. Muir, to create a board of naturopathic examiners, was referred to the Public Health Committee, where it died.

Senate Bill 15, sponsored by the New Jersey State Dental Society to further curb certain types of advertising, was endorsed by this Committee, and we appeared in support of the measure at a public hearing Monday evening, April 2nd. Representatives of the New Jersey State Nurses' Association also spoke in behalf of the bill.

It may be recalled that Senator Stanger introduced Senate Bill 113 (referred to in Bulletin No. 1, March 21st), which was designed to permit a graduate of an *unapproved* school to take the examination for licensure to practice medicine in this state. The fact that a bill was passed in New York State in March (we have since learned that this bill was vetoed by the Governor on April 21st) permitting graduates of *unaccredited* schools to take the examination for licensure in that state until July, 1946, made this bill (S-113), potentially, very dangerous. Fortunately, however, at final adjournment the bill was still in committee.

Senate Bill 236, introduced March 23rd, which forbids the manufacture and sale of bread unless enriched with certain vitamins, remained in Committee. Our information is that this measure was discussed in conference by the Senators of the majority party and that their reaction to it was that it smacked too much of regimentation; that the results sought would come about in response to public demand through education. Whether the Senators' opinions here are correct or not, the views of the legislators, in large measure at least, determine legislative results.

One Bill (A-143), to create a migrant labor division in the Department of Labor to regulate migrant labor camps, we were able to have amended satisfactorily in the Senate, so as to eliminate a section which would have set up a very objectionable pattern of medical care by the State for migrant laborers, and thus have established an unwholesome precedent. It has passed both Houses with the Senate amendment suggested and has been signed by the Governor. The amending of this bill and the reasons for it, we believe, are sufficiently important to describe fully.

Section 11 of the Bill, before amending, read as follows:

> "11. Medical, clinical and hospital services. The commissioner shall *provide essential medical, clinical and hospital facilities for occupants of camps,* (italics ours) to the extent of available appropriations, as need appears. Such services may be provided through the use of one or more traveling dispensaries, by contract with local physicians, dentists, hospitals or clinics, by coöperative arrangements with the Department of Health, or in such other manner as the commissioner may determine."

The section substituted for this was the result of careful consideration of this Section by the State Department of Health and this Committee, and reads as follows:

> "11. Provision of preventive and curative public health services. The Division through the Department of Health shall make surveys to determine the adequacy of preventive and curative health services available to occupants of migrant labor camps, and where such services are found inadequate, to determine desirable ways and means to make them available. The Commissioner shall arrange, to the extent of the available appropriations, through the Department of Health for the provision of such supplementary services. Said services may be provided through the use of one or more traveling dispensaries, by a contract with physicians, dentists, hospitals or clinics, or in such other manner as may be recommended by the Department of Health."

In presenting this amendment for consideration of the Senators the following reasons were given for recommending the amendment:

> "It is feared that section (11) in its present form would give rise to the belief that the State is assuming responsibility for the provision of all medical, clinical and hospital services for migrant workers—in other words, that the State intended to set up a complete system of State medicine for migrant workers. In view of the size of the appropriation this obviously is not the intent, but the misunderstandings which would arise would undoubtedly cause many employers who are now supplying medical services to discontinue such services, and the net result might actually be a decrease in medical services to migrants. Furthermore, any supplementing of medical services to migrants must be very carefully coördinated with presently existing services. It is for this reason that provision is made for a survey to be performed by the department best equipped to do so. Also the provision

of medical and health services is channeled exclusively through the Department of Health."

There are two subjects which may be regarded as hold-over legislation, and which are of such extreme importance to the profession as to deserve discussion in this report.

1. *Reorganization of the State Department of Health*

This subject was brought into focus by the "Williams' Report" made during the latter part of the administration of former Governor Edison. Added impetus to the likelihood of reorganizing the Health Department was given by Governor Edge by his advocacy, in his inaugural message, of the reorganization and consolidation of the various departments and agencies of the State government.

Assembly Bill 404, which was proposed by the Commission on State Administrative Reorganization, and introduced, *for study,* the day before final adjournment of the Legislature (April 9th) is designed to effect the reorganization of the Department of Health.

As we have said the Bill was introduced at this session for study *only.* It will be reintroduced and acted upon next year. We shall endeavor in the interval to analyze the measure most carefully and we express the hope that representatives of all County Societies will do likewise.

2. *Boards of Examiners and Licensure*

For a time it was the apparent intention of the Commission on State Administrative Reorganization to include in the bill reorganizing of the State Department of Health, a division of licensure, to include the Boards of Examiners of the Medical and Allied Professions. This idea has been discarded, but we must assume that the Commission will propose a bill next year to create a division of licensure in one of the other major departments of the State government. It is idle to speculate upon this at the moment, although it has been intimated from a credible source, that a division of licensure may be proposed for inclusion in the Department of State.

In the National Legislature, of pending bills having medical interest, the most important so far proposed is S-191 by Mr. Hill (for himself and Mr. Burton), introduced January 10th and referred to the Committee on Education and Labor. We shall attempt to call attention to the most salient features of this Bill.

The Bill proposes to amend the Public Health Service Act to authorize grants to the States for surveying their hospitals and public health centers and for planning construction of additional facilities, and to authorize grants to assist in such construction. Provision is made in the Bill for an appropriation of five million dollars, which is to be allotted to the states on a percentage basis, and in accordance with the states' financial ability, to carry out a survey of hospitals and related facilities.

Before application for funds to carry out this survey will be approved it is necessary "(1) to designate a single state agency as the sole agency for carrying out such purposes; (2) to provide for the designation of a state advisory council, which shall include representatives of non-government organizations or groups, and of state agencies, concerned with the operation, construction, or utilization of hospitals, to consult with the state agency in carrying out such purposes."

One hundred million dollars is the authorized appropriation for hospital construction by the states for the fiscal year ending June 30, 1946. Before approval of a state plan for carrying out a hospital construction program the state must designate a single state agency as the sole agency for the administration of the plan, or designate such agency as the sole agency for supervising the administration of such plan, and the plan itself must have the approval of the Surgeon General and the Federal Advisory Council.

The term "hospital" is defined in the Act as follows: "The term 'hospital' includes public health centers and general, tuberculosis, mental, chronic disease, and other types of hospitals, and related facilities, such as laboratories, out-patient departments, nurses' home and training facilities, and central service facilities operated in connection with hospitals, but shall not include any hospital furnishing primarily domiciliary care."

It seems to us that the wording of the bill creates the impression that its sole purpose is to create a hospital construction program. Actually the construction of the hospitals and related facilities is merely incidental to the advancement of the public health program contemplated by this Bill. This Committee recommended, therefore, that the Bill be amended by substituting for the word "hospital" the phrase "public health facilities" and then define "public health facilities" to include hospitals and related facilities as set forth in the act; and, that if this recommendation met with the approval of the Welfare Committee it be forwarded to the Board of Trustees for its approval with the suggestion that the recommendation be forwarded to the Board of Trustees of the American Med-

ical Association and to its Bureau of Legal Medicine and Legislation. The Bill is still pending and it is therefore quite possible that such an amendment might be made before the measure is voted upon.

The Welfare Committee at its meeting April 8th, adopted this recommendation and the action was concurred in by the Board of Trustees on April 15th.

If we realize, as we all too often do not, that the medical profession represents a relatively small proportion of the total population of the States and Nation, we may indeed count ourselves fortunate that thus far, at least in this State, we have been able through our influence and prestige to have aided in the passage of much worth-while public health legislation, and to have helped in the defeat of considerable vicious legislation affecting public health. That we shall continue to occupy this fortunate position legislatively, there is much reason to doubt, unless the Society institutes a public relations program that will bring our point of view to the larger and more influential segments of the population.

With the present social trends, the number of large and influential groups—labor, agriculture, industry and business—who are becoming increasingly interested and vocal in the matter of medical care and its distribution, as evidenced by the flood of bills being introduced in the National and State Legislature, the need, in our opinion, of a well-considered public relations program is urgent. We would strongly recommend, therefore, the institution of such a program—this program to be integrated with those of the Legislative and Medical Practice Committees.

I want to thank the members of the Committee and the County Society Keymen for their coöperation, and I particularly want to express my own appreciation and that of the Committee for the excellent services which Dr. Frederic J. Quigley, Executive Secretary of the Committee, has rendered throughout the year. We have reason to feel fairly well satisfied with our efforts at this session of the Legislature, and we are indebted in large measure to Dr. Quigley for our success. I feel that special mention should be made of his work in connection with the chiropractic hearings last fall and in checking any move made by the chiropractors during this session.

The Committee would also like to express its appreciation to our President, who has always been ready to aid us when called upon.

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## MEDICAL PRACTICE

SIGURD W. JOHNSEN, M.D., Chairman, Passaic

The Subcommittee on Medical Practice and its Advisory Committees, in accordance with the wishes of our President, Dr. Londrigan, have confined their activities to only the most essential matters.

Three meetings of the Subcommittee on Medical Practice have been held, and the reports have been published in *The Journal*.

The Post-War Planning work of the committee has been continued, and, as a result of last year's work, progress is being made in a number of directions. A report on Post-War Planning is included as supplement to this report.

The Chairmen of the various Advisory Committees have coöperated fully and have given their time and efforts unstintingly in carrying out their programs.

We wish to express our appreciation and thanks to our President, Dr. Londrigan, who has coöperated with us in every way.

SUPPLEMENTAL REPORT

### POST-WAR PLANNING

This year has brought forward new and old proposals for the establishment of compulsory health insurance schemes on a state as well as a national basis.

California has thirteen bills before its present legislature relating to medical care. Two of these are very much alike—one introduced by the C. I. O. and the other by Governor Warren. In the Journal of the A. M. A., February 17, 1945, pages 405-406, both bills are analyzed. They are compulsory health insurance schemes supported by wage deductions of 1½ per cent paid by the employee and 1½ per cent by the employer. The benefits provided in these bills include general medical care, specialist and hospital services, laboratory and x-ray services, dental care, as well as drugs and medicines. Both bills were defeated.

A bill has been introduced into our own New Jersey Legislature to enact a system of cash sickness compensation, payable to persons unable to work because of illness.

The Wagner-Murray-Dingell Bill has been reintroduced into the House of Representatives in Washington, as well as other bills providing for new hospital construction and state aid for medical care.

As was expected, the movement for compulsory health insurance schemes of all kinds has been accelerated. In spite of the excellent work done by the National Physicians Committee, by the A. M. A., and all of the educational work and propaganda of the State Medical Societies, we are confronted by a greater demand than ever before, for this type of legislation. The program is backed by the C. I. O. and the A. F. of L., as well as all sorts of welfare and social agencies. It is receiving attentive consideration by our legislators of both the Democratic and Republican parties.

Public surveys conducted by responsible organizations have revealed the contradictory fact that there is a great demand for prepayment plans of medical care and also for free choice of physician and free selection of medical care. Obviously, there is a general demand for as much service as possible for a limited fee, with continued individual choice of the physicians to render these services.

Plans are under way to put into effect large scale voluntary health insurance plans such as Mayor La Guardia's New York Plan to provide complete medical care on a prepayment basis. There has been a moderate increase in the sale of contracts by Medical Society-sponsored Voluntary Health Insurance Plans with limited coverage, but these plans have not shown any striking example of large scale acceptance.

Voluntary hospitalization plans have continued to increase in popularity and the movement to include medical services in these plans is gaining ground rapidly.

Industrial plans for coverage of workers and providing full medical care, such as the Kaiser Plan, etc., continue to gain in popularity and in numbers.

A large-scale expansion of medical care facilities for veterans is now under way. Increased appropriations for additional hospitals have already been made. When the veterans of this war are added to those of the last war it is estimated that 300,000 beds in Veterans Hospitals will be needed. There are 91,000 beds available now. With non-service connected disabilities included in the care of veterans where inability to pay is claimed by the veteran, it can readily be seen that a large segment of our citizens will be cared for by the Veterans Administration.

This is briefly an appraisal of trends which at the present time are definite and in a process of acceleration.

Whether we approve or disapprove, the trends are unmistakable. Therefore, if we wish to modify or alter any of these trends, immediate steps will have to be taken before it is too late.

# ADVISORY COMMITTEES

# MEDICAL PRACTICE

## AUXILIARY MEDICAL SERVICES

W. JAMES MARQUIS, M.D., Chairman, East Orange

There have been no meetings of the Advisory Committee on Auxiliary Medical Services.

## CONTRACT PRACTICE

ANDREW C. RUOFF, M.D., Chairman, Union City

As stated in last year's report, the Advisory Committee on Contract Practice usually functions upon the request of the Subcommittee on Medical Practice, or at the request of the President of the Society. In the past year, the Committee has endeavored to clear up matters that had been carried over from previous years. We did succeed in getting the Veterans Administration to allow the doctors of our Society the fees that we deemed fair and adequate, as was reported in the February *Journal*.

We have had the matter of fees to doctors, doing work for the various railroads, on our agenda for some years. Nothing has been accomplished in this respect largely because the subject is a broad one, and there has been a general disinclination to probe into the equities of the subject.

## DISTRIBUTION OF MEDICAL CARE

ROBERT M. GRIER, M.D., Chairman, Pleasantville

The Committee on Distribution of Medical Care has had an extremely "stream-lined" year. Limitations placed on travel and the magnitude of work on the shoulders of the members of the committee have made meetings almost prohibitive. Therefore our report for the year can only be a "progress report".

Our duties as a committee are: first, to protect the interests of our fellow practitioners who are away in the armed forces; second, to see that the practice left by the Armed Forces doctor is kept in a condition as close as possible to the way he left it; third, to keep a careful watch on newly licensed physicians, especially those coming from foreign countries; and last, to be ever watchful of those signs which point to an increase in the number of people receiving medical care under some so-called insurance or socialistic plan.

The failure of the Wagner-Murray-Dingell bill is only a lull in the storm of the approaching social medical bills. We have tried to keep abreast of bills which pertain to medical practice as they are announced. We know that this is a major function of our committee.

We have heard of medical service being extended to families of Veterans. Denial that such is true has been received from the Administrator of the Veterans Bureau. We know it has occurred and when the investigation is complete, it will be duly recorded. This must not be construed as action against Veterans (the chairman of this committee is at present Commander of an American Legion Post). The investigation will be complete because we know that group medical service from underpaid Administration men is not the type of medical service they deserve.

Further than the above, the committee reports progress.

## INDUSTRIAL HEALTH AND HYGIENE

J. M. CARLISLE, M.D., Chairman, Westfield

For the Annual Meeting of The Medical Society of New Jersey held in Atlantic City, April 25-27, 1944, your Committee prepared an exhibit on "Clinical, Electrocardiographic and Pathologic Correlation of Certain Common Cardiac Conditions". The American Association of Industrial Physicians asked that it be shown at their Annual Meeting in May, 1944, in St. Louis, where it was exceedingly well attended. From there the exhibit was sent to the Annual Meeting of the Medical Society of Wisconsin held in Madison, September 18-20, 1944.

A second exhibit was prepared by your

Committee on "Clinical and Pathologic Observations in Industrial and Civil Injuries". This exhibit was shown at the following meetings:

American Medical Association, June 12-16, 1944, Chicago.
Interstate Post-Graduate Medical Association Assembly, October 17-20, 1944, Chicago.
Southern Medical Association, November 13-16, 1944, St. Louis.
United States Army, Carlisle Barracks.

The series of lectures to Industrial Nurses has been continued in coöperation with Rutgers University. Moreover, this lecture course has been extended and is now offered through the facilities of Seton Hall College as a 32-hour lecture course. Other lectures given by members of your Committee during the past year are:

"The Care and Prevention of Occupational Injuries", Seton Hall College, March 14, 1944.
"Improvement in Nutrition as a Protection Against Industrial Toxicity", Twenty-second Annual Conference of Milbank Memorial Fund, New York Academy of Medicine, April 13, 1944.
"Medical First Aid and Definitive Treatment of Chemical Injuries of the Eye", Seminar on Industrial Aspects of Ophthalmology, National Society for the Prevention of Blindness, New York, May 4, 1944.
"Absenteeism", Hercules Powder Company, Roanoke, Virginia, September 8, 1944.
"Chemical Burns and Their Treatment, Including a Discussion of Pulmonary Irritants and the Use of the Spirogram as a Valuable Diagnostic Aid in These Cases", Industrial Hygiene Course at Columbia University, New York, December 1, 1944.
Symposium on "Veterans in Industry", New Jersey Association of Industrial Physicians, Academy of Medicine, Newark, January 12, 1945.
"The Rôle of the Physician in Industrial Absenteeism", Morris County Medical Society, Dover General Hospital, Dover, New Jersey, January 18, 1945.
"Industrial First Aid in Chemical Injuries of the Eye", Industrial Ophthalmology Course at Columbia University, New York, May 11, 1945.

The subject of Physical Medicine in Industry is becoming one of increasing importance. We have met with several groups in an effort to extend these facilities in industry. Four papers on the subject have been published by members of your Committee.

A Joint Conference on Industrial Health, Hygiene and Safety was prepared for March 15, 1945, in coöperation with the New Jersey Department of Labor, New Jersey Department of Health, the American Society of Safety Engineers, the Chamber of Commerce, the New Jersey Chapter of the National Association of Manufacturers, and other organizations.

The rôle of the private physician in the issuance of medical certificates for industrial absenteeism has been a subject of nation-wide discussion. Since industrial absenteeism has played a tremendous rôle in our war production, several meetings have been held in an effort to place before the private physician the various abuses of his medical certificate. An editorial on this subject has been prepared which we hope will be published in an early issue of *The Journal.*

Your Committee had accepted the responsibility of a major portion of the program for the Congress on Industrial Health to be held under the auspices of the American Medical Association in Chicago on February 13-15, 1945, subsequently cancelled.

The following papers were prepared for presentation and publication by your Committee:

"Physical Medicine in Industry", published in Industrial Medicine, September, 1944.
"Clinical, Electrocardiographic and Pathologic Correlation of Certain Common Cardiac Conditions and Evaluation of the Cardiac Patient in Industry", published in Industrial Medicine, October, 1944.
"Industrial Medicine in the Chemical Industry."
"The Importance of Accurate Diagnosis of Occupational Diseases."

Progress has been made in our program of Graduate Education in Industrial Medicine. We are coöperating with Rutgers University and the State Society's Committee on Graduate Education in this very important field. We are now prepared to activate the program as we have it outlined. It is our hope that such a graduate course will be readily available to physicians returning from the armed services.

# MEDICAL CARE OF THE INDIGENT AND LOW-WAGE GROUP

GEORGE BLACKBURNE, M.D., Chairman, Newark

The first portion of this report embodies a memorandum from Dr. Norman Scott who is in charge of the administration of several agencies dealing with the care of the Indigent and the Medically Indigent throughout the State of New Jersey.

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There has been a rapid and progressive decrease in the indigent roll of New Jersey since the beginning of the war period.

As of January, 1944, the indigent load of the state involved 12,078 people, which was reduced by December, 1944, to 8,098.

Medical care of the indigent in New Jersey is provided for through the State Municipal Aid Administration under an arrangement by which the state bears a percentage of the costs based upon a formula which is in turn based upon the tax ratables of each community. Of the 576 municipalities in New Jersey, about 350 coöperate with Municipal Aid. The municipalities which do not coöperate are as a rule very small rural municipalities with no indigent problem. A better way to express it is that Municipal Aid covers 90 per cent of the population of New Jersey.

Since November, 1943, the indigent of Newark have been provided with medical care when confined to their homes by illness through Medical Service Administration on the basis of an informal memorandum with the City of Newark. This is our first opportunity therefore, to present our experiences for one full twelve month period. We have chosen the twelve-month period of 1944 rather than the twelve-month fiscal year of the Society.

### INDIGENT (RELIEF CLIENTS)

The "indigent" are those persons whose names appear on the welfare rolls of the City of Newark. As of January 1, 1944, these numbered 2,871 persons or about 23 per cent of the total of the indigent load for the state. By December, 1944, the indigent load of Newark had been reduced to 1,754 persons. The mean indigent load for the year is estimated at 2,082 persons. Our experience with the indigent for the year 1944 and the cost per person is depicted in the following table:

| | |
|---|---|
| Mean number of persons on welfare rolls | 2,082 |
| Claims for 1944 | $1,984.00 |
| Number persons treated 1944 | 359 |
| Cost per person on welfare rolls: | |
| Per year | $ .95 |
| Per month | .08 |

### MEDICALLY INDIGENT

In January, 1944, the City of Newark requested that we expand the City of Newark Plan to include the care of the medically indigent. The medically indigent are those persons who when applying to the Department of Health for medical care, are considered medically indigent after investigation by the Social Service Department of the Department of Health. In determining costs it is not possible to determine the cost per person as based upon the total medically indigent load of Newark. The medically indigent load is undoubtedly much greater than the load depicted in this report which is limited to those families who upon application for medical care were classified as medically indigent. Therefore cost estimates must be based upon the actual number of persons receiving treatment. It is gratifying to us to know that we have made even this small progress with the medically indigent problem. Our experience with this group for the twelve-month period of 1944 is depicted as follows:

| | |
|---|---|
| Claims for 1944 | $1,260.00 |
| Number families involved | 435 |
| Number persons treated in 1944 | 519 |
| Cost per family per year | $ 2.89 |
| Cost per family per month | .24 |
| Cost per person per year | 2.43 |
| Cost per person per month | .20 |

### FARM SECURITY MEDICAL PLAN

This Plan is included in our report to your Committee because it represents a group of medically indigent persons. They are a group of low-income farmers with no tangible assets upon which to borrow money from banks, who have been loaned money by the federal government for purposes of rehabilitation. We have operated the Farm Security Medical Plan for four years, providing essential medical care in the homes of the clients and offices of the physician for a subscription rate varying from $16.00 to $24.00 per year depending upon the size of the families and providing for a fee schedule of $1.50 in the office and $2.50 in the home. The Plan has not been completely satisfactory because of its limitations. These families need a more comprehensive plan, providing for the cost of hospitalization and medical and surgical care in hospital, but for the present we see no way of providing such a plan. The income of these people would not support the costs of a complete plan. The sick

rate and amount of disabilities in this group are so great that it would be impossible to determine actuarially a subscription rate to cover the costs of a more complete plan. In past years the Plan has experienced serious deficits. For the year of 1944 our experience was better, probably because we have corrected many minor defects in these families in the past years and the novelty of being able to request medical care without additional cost is worn off. When first inaugurated this Plan was operated by a lay group. That arrangement was not satisfactory to physicians or clients. Medical Service Administration took it over to bring it under the control of the profession and to prevent further lay control of medical care distribution. We believe the Plan is very worthwhile despite its defects. It has been a very definite benefit to these families and has provided an income equal to $4,600 per year per thousand persons to the medical profession. The income to the profession is not adequate, but is greater than they would otherwise receive from this group. We recommend that the Plan be continued. Our experience for the year is as follows:

| | |
|---|---|
| Mean number families 1944 | 395 |
| Mean number persons 1944 | 1,677 |
| Claim cost as paid for 1944 | $7,760.96 |
| Subscription income applicable to 12 months of 1944 | 8,187.00 |
| Subscription income per family per year (1944) | $ 20.72 |
| Claim cost, as paid, per family per year (1944) | 19.64 |
| Subscription income per family per month (1944) | $ 1.73 |
| Claim cost, as paid, per family per month (1944) | 1.64 |
| Subscription income per person per year (1944) | $ 4.88 |
| Claim cost, as paid, per person per year (1944) | 4.63 |
| Subscription income per person per month (1944) | $ .41 |
| Claim cost, as paid, per person per month (1944) | .39 |
| Pro-ration of Physicians' Fees (1944) | |
| March, 1944—25% deducted in all cases | |
| July, 1944—10% of fees for all visits excepting one visit cases | |
| October, 1944—20% of fees for all visits excepting one visit cases | |
| Reserve in Farm Security Medical Plan Account December 31, 1943 | $ 560.30 |
| Reserve in Farm Security Medical Plan Account December 31, 1944 | 774.62 |
| Increase in reserve | $ 214.32 |

The amount of money involved in the proration of Physicians' Fees was $371.30. The Plan actually made a gain in reserve in the amount of $214.32 but had all physicians' fees been paid in accordance with 1005 of the fee schedule, we would have had a deficit of $156.99 for the year.

REMARKS

All of the above figures as related to income do not include administrative costs. The income from the Farm Plan represents the gross subscription income less 10 per cent which was deducted for administrative costs. The City of Newark adds 10 per cent to the amount billed them each month to cover administrative costs.

All deficits for the work done by Medical Service Administration are borne by The Medical Society of New Jersey. We frequently get comments to the effect that this work is too expensive to the Society. It does cost money, but it is basic information which must be obtained if the medical profession is to understand the medical care distribution problem and its costs. We must have a knowledge of these things if we are to properly protect the future welfare of the profession. We therefore request the support of this Committee in continuing all of this work as part of the program of The Medical Society of New Jersey and that the deficits in administrative costs be covered by a budgetary item of the Society.

Your Committee has suggested that our program for the care of the indigent be expanded to a state-wide basis. We should welcome such an expansion but at present it is not practical for the following reasons. There is no common pattern providing medical care in our various municipalities and in accordance with New Jersey law it is a responsibility of the muncipalities. Some municipalities still employ city physicians. Others provide fee for service with free choice of physician, while I believe others provide fee for service to a designated city physician. It would be a very expensive administrative procedure to deal with the 500 small municipalities in New Jersey, who would have at present only one or two indigent families. It would be very expensive and almost impossible from an administrative standpoint to conduct a plan for the indigent including the multiple arrangements which would be re-

quired by these individual municipalities. If care of the indigent could be placed on a county basis so that Medical Service Administration had to deal with only twenty-one agencies, it would be a great advantage. At present only Warren and Morris Counties handle indigent cases through County Welfare Boards.

The physicians of Newark are particularly grateful to Commissioner John A. Brady for his whole-hearted coöperation in the efforts to provide adequate medical care to the indigent and medically indigent cases in that city.

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The Committee on Medical Care of the Indigent and Low-Wage Group recommends that each County Society in the State be contacted through the Executive Office of the State Society and be requested to supply the following information:

1. How are the indigent and low-wage groups handled in your County from a medical standpoint?

2. How are the indigent chronic ill cared for?

3. How are the medically indigent cared for?

4. Is adequate medical care available for everybody?

5. What suggestions have you to offer for better medical care for the indigent sick and low-wage group?

A summary of the above would be most valuable at this time when we are being challenged to either lead the way or be led.

Your committee strongly recommends a local government subsidy in the care of the above mentioned groups, but not State or Socialized Medicine in any form.

## NURSING AND NURSING EDUCATION

WALTER E. D'ARCY, M.D., Chairman, Trenton

The Advisory Committee on Nursing and Nursing Education has held no meetings during the year. The President referred one item to the Committee for consideration: A request from the North Atlantic Area, American Red Cross, for approval of a program for training selected nurses' aides to assist graduate nurses with the care of poliomyelitis patients. The Committee members were canvassed by mail and recommended approval of this program. The recommendation was subsequently endorsed by the Medical Practice and Welfare Committees.

## PHARMACEUTICAL PROBLEMS

CHESTER I. ULMER, M.D., Chairman, Gibbstown

One meeting of the Committee was held during the year. It was a joint conference with a committee from the State Pharmaceutical Association. One of the matters discussed was the increasing confusion and multiplicity of names of pharmaceutical preparations. It is planned to study this matter with the hope of simplifying the nomenclature of these medications. This is a feasible project.

## PRIVATE PRACTICE

HARRISON B. WILSON, M.D., Chairman, Hackensack

I have no report to submit this year. The condition of our committee has been static during the last twelve months, the coming year should bring more work.

## WORKMEN'S COMPENSATION

WILLIAM K. HARRYMAN, M.D., Chairman, Hackensack

This year has been a rather quiet one for this Committee. A number of letters sent to the Committee by outside agencies have been answered to the best of our ability. Several meetings have been held with various other committees with satisfactory results and a number of bills introduced into the legislature affecting workmen's compensation have been reviewed and opinions passed upon them. The committee must continue to be vigilant.

# PUBLIC HEALTH

## CANCER CONTROL

FLOYD E. KEIR, M.D., Chairman, Englewood

A Cancer Control meeting was held at the Elizabeth General Hospital on Sunday, November 26, 1944, and the following recommendations were made:

1. That an up-to-date list of Tumor Clinics in the state together with the names of the directors be placed on file at the State Medical Society Executive Office in Trenton. Also a copy of the rules and regulations governing these clinics.
2. That the association of Tumor Clinics be the guiding force in the development of the cancer control work in the State of New Jersey.
3. That the State Executive Committee of the Women's Field Army include in its membership the entire personnel of the Cancer Committee of the State Medical Society.
4. That the preventive control of cancer be a part of the established Cancer Clinics throughout the state.
5. That the key man in any successful cancer control program be the family physician. The committee feels that any program of cancer control that does not properly incorporate the activities of the family physician is bound to fail.

The Chairman suggests a program of coordinating all the interested agencies and groups in Cancer Control and evaluating their respective responsibilities and duties. This is a large task and some states, for example, Texas, have placed the leadership in the hands of the State University.

## CHILD HEALTH

HARROLD A. MURRAY, M.D., Chairman, Newark

The chief interest of the Child Health Committee during the past year has centered in formulating suggestions for the prevention and control of infectious diarrhea of the new-born infant. We felt that the prevention of this highly fatal condition in infancy could best be attained by combining standards suggested by various agencies.

Many meetings were held with representatives from the State Board of Health, the American Academy of Pediatrics and the State Board of Nursing Examiners. From these discussions many practical suggestions have been formulated. These in printed form will be sent to each hospital in the State that has a new-born nursery.

The Committee has been interested in the care of children handicapped with rheumatic heart disease. We plan to combine our efforts for the convalescent care of these children with various interested State and local committees and agencies.

In our post-war planning we have considered the formation of a program for mental hygiene in children. This will be much needed in the next few years.

The committee is anxious to actively coöperate with the Physical Fitness Program in the State of New Jersey.

## CONSERVATION OF VISION AND HEARING

Elbert S. Sherman, M.D., Chairman, Newark

Because of the announced policy of the Society that committee activities be reduced to a minimum during the present emergency, and as no matters have been referred to our committee during the year, no meetings have been held.

## MENTAL HYGIENE

Joseph E. Raycroft, M.D., Chairman, Trenton

With the changing conditions, the work of the Committee on Mental Hygiene is increasing as the veterans suffering with psychoneuroses are returning. In order to develop contacts with similar committees of other organizations so that there will be close coördination and coöperation in the examination and treatment of these veterans and others of the civilian population, it was recommended that the President enlarge the membership of the Committee. The enlarged Committee has held one meeting at which time the increased program was discussed. Following the resignation of your Chairman because of ill health, the Committee elected Dr. Arthur P. Hasking of Jersey City to the chair.

## MATERNAL WELFARE

Walter B. Mount, M.D., Chairman, Montclair

Two meetings have been held; the first in Newark on November 8, 1944, which the President and Chairman of the Board of Trustees were gracious enough to attend; the second in Trenton on April 8, 1945, at which the Chairman was the only one present.

The field physicians have worked faithfully and most of the hospitals have returned their annual obstetrical reports. In many counties, meetings of the county committees on maternal welfare have been held at varying intervals.

In accordance with the decision of the Board of Trustees to centralize the work of the Committee in the central offices in Trenton, the records and statistics have been forwarded to the Executive Offices from which the annual statistical records will be formulated.

The Committee acknowledges its indebtedness to Dr. Julius Levy and the Bureau of Maternal and Child Health for their coöperation in furnishing the requested statistical data. Dr. Levy has promised continued and further assistance in the compilation of the statistics.

The three major causes of maternal deaths—infection, toxemias, and the group comprising hemorrhage, trauma, or shock—were responsible for 85.6 per cent of the 118 deaths in 1944. The remaining 17 deaths were due to other and unspecified causes or were not reported.

Infection was the leading cause of maternal mortality. It was responsible for 45 (38 per cent) of the deaths. The death rate from this cause was 6 per 10,000 live births. Hemorrhage, trauma, and shock were the cause of 38 (32 per cent) of the deaths with a death rate of 5 per 10,000 live births. Toxemias were responsible for 18 (15 per cent) of the maternal deaths and the rate from this cause was 2.5 per 10,000 live births.

During 1944 there were 75,652 resident births in the State. With only 118 maternal deaths for the year, the maternal mortality rate for New Jersey in 1944 was 16 per 10,000 live births, the lowest recorded. Twenty deaths occurring during pregnancy were not attributable to puerperal causes.

The following tables outline the principal causes of death in the State and by counties.

TABLE NO. 1

1944 MATERNAL MORTALITY STATISTICS

| Causes of Death | Total | Time of death in relation to delivery: Ectopic Gestation | During or After Abortion | Before Delivery | During or After Childbirth |
|---|---|---|---|---|---|
| | | | Number | | |
| All causes | 118 | 4 | 28 | 12 | 74 |
| Infection | 45 | 2 | 20 | .. | 23 |
| Toxemias | 18 | .. | 2 | 6 | 10 |
| Eclampsia | 5 | . | .. | 1 | 4 |
| Albuminuria and nephritis | 4 | .. | .. | 2 | 2 |
| Acute yellow atrophy | 4 | .. | .. | 1 | 3 |
| Other | 5 | .. | .. | 4 | 1 |
| Hemorrhage, trauma or shock | 38 | .. | 2 | 3 | 33 |
| Other and unspecified causes | 12 | 2 | 4 | 3 | 3 |
| Unreported | 5 | .. | .. | .. | .. |

TABLE NO. 2

DISTRIBUTION OF MATERNAL DEATHS BY TIME OF DEATH IN RELATION TO DELIVERY IN EACH COUNTY BY PLACE OF RESIDENCE

| County (Number of Births in 1944) New Jersey (75,652) | Total Deaths | Abortion | Ectopic Gestation | Before Delivery | During or After Childbirth |
|---|---|---|---|---|---|
| Atlantic (1,963) | 8 | 4 | .. | 1 | 3 |
| Bergen (7,574) | 10 | 2 | 1 | 2 | 5 |
| Burlington (1,869) | 2 | 1 | . | ... | 1 |
| Camden (4,976) | 15 | 5 | .. | 1 | 9 |
| Cape May (548) | 1 | .. | .. | .. | 1 |
| Cumberland (1,479) | 3 | .. | .. | 1 | 2 |
| Essex (15,077) | 15 | 3 | 1 | 2 | 9 |
| Gloucester (1,464) | 1 | 1 | .. | .. | . |
| Hudson (10,765) | 13 | 4 | 1 | .. | 8 |
| Hunterdon (533) | .. | .. | .. | .. | . |
| Mercer (3,547) | 10 | 1 | .. | 2 | 7 |
| Middlesex (4,000) | 8 | 2 | .. | .. | 6 |
| Monmouth (3,433) | 7 | 3 | .. | . | 4 |
| Morris (2,323) | 3 | .. | .. | .. | 3 |
| Ocean (754) | .. | .. | .. | .. | |
| Passaic (5,119) | 3 | .. | .. | .. | 3 |
| Salem (934) | 2 | .. | .. | .. | 2 |
| Somerset (1,504) | 1 | .. | .. | 1 | .. |
| Sussex (593) | 1 | .. | .. | .. | 1 |
| Union (6,442) | 9 | 2 | 1 | 2 | 4 |
| Warren (755) | 1 | .. | . | .. | 1 |
| Unreported | 5 | | | | |

## SCHOOL HEALTH

WILSON G. GUTHRIE, M.D., Chairman, Trenton

There has been no meeting of the Advisory Committee on School Health.

### JOINT PHYSICAL FITNESS ADVISORY COMMITTEE

There has been one meeting of the Joint Physical Fitness Advisory Committee. This committee is composed of six physicians who are members of The Medical Society of New Jersey and six physical education and recreation individuals. The Physical Fitness Program for the State of New Jersey is under the promotion of the Community War Services Committee of the State Civilian Defense. The Joint Physical Fitness Advisory Committee met and considered the following items:

1. Discussion of the National Physical Fitness Program as it applies to New Jersey.
2. The function of this committee in this program.
3. Help in the construction of the State Program of Physical Fitness.
4. Coöperation of this committee with other groups promoting the Physical Fitness Program.
5. It was decided that a program be drawn

up by this committee emphasizing Medical Fitness and also Physical Fitness. When completed, copies of this program will be submitted to the Community War Services Committee and to the Public Health Committee of The Medical Society of New Jersey.

## TRAFFIC ACCIDENTS AND SAFETY

GARNETT SUMMERILL, M.D., Chairman, Camden

The Advisory Committee on Traffic Accidents and Safety is dormant at the present time due to the war.

Any recommendations that may be submitted on Traffic and Safety will not be made until the war is concluded.

## TROPICAL DISEASES

CHRISTIAN P. SEGARD, M.D., Chairman, Leonia

This Committee was appointed the latter part of 1944, and, therefore, this report covers only a part of the year.

At the meeting of the Public Health Committee in October, 1944, the Committee on Tropical Diseases made the following recommendations:

1. That the Committee communicate with other states having committees on Tropical Diseases, so that uniformity of state committees' actions could be carried out. The Committee communicated with all states having seaboard, and found that there were no other committees on Tropical Diseases in existence in any of the states so far contacted.

2. That the Committee be permitted to have technical advisers. Four technical advisers were appointed and assisted the committee whenever requested.

3. That the Committee communicate with the Surgeons General as to the best method of coöperation between them and the State Medical Society regarding discharged service men. Owing to lack of time and inability to see the Surgeons General on this important recommendation, it has been left to be carried out in the near future.

4. That the Committee prepare a bulletin to be distributed. This bulletin has been prepared and was printed in the January *Journal* of the Society and reprints have been distributed.

The Committee is indebted to the Advisers to the Surgeons General on Tropical Diseases as well as to the four technical advisers who so kindly helped the committee prepare the bulletin.

## TUBERCULOSIS AND ADULT DISEASE CONTROL

JOSEPH R. MORROW, M.D., Chairman, Oradell

Following the recent precedent which had been set, due to the unusual burdens being carried at this time, there were no special meetings of this Committee last year. The minor affairs of the Committee were readily handled through informal consultations with the Committee and Welfare Committee members.

A Federal Government appropriation of $10,000,000 has been made to further mass industrial surveys throughout the United States. In New Jersey this program is carried out by the State Health Department in conjunction with the Federal Bureau of Public Health. The appropriation will be used principally in those sections where little or no previous survey work has been accomplished. A part of the fund is intended to enlarge the program in New Jersey and other sections where considerable progress has already been made. It will be recalled that last year the Tuberculosis and Adult Disease Committee unanimously endorsed industrial x-ray surveys for the discovery of tuberculosis.

Scattered and admittedly inconclusive re-

ports already submitted continue to bring forth statements and predictions concerning a rise in tuberculosis incidence. Much more study will be necessary to determine the accuracy and extent of such indications; but the continuation and enlargement of the industrial survey program is considered by the Federal and State Health Bureaus to be necessary for the safe control of tuberculosis.

The use of 4 inch by 5 inch and 35 mm. x-ray films in this type of work has proved effective in permitting a wider program within the funds available. It has also been responsible for maintaining the former volume of work done, since in many instances the curtailed supply of x-ray films would have forced a considerable reduction in volume had the 14 inch by 17 inch films been used exclusively.

While the Federal Government has made provision for the hospitalization of World War II veterans suffering from tuberculosis, the veteran is given the option of entering other hospitals for the treatment of tuberculosis. A normal desire to be close to his home and family, plus the many other considerations involved, can be expected to result in discharged veterans seeking admission to State and County tuberculosis hospitals. There are already instances where such applications have been made, and it will be necessary for the established hospitals to be prepared to care for some of the veterans involved.

During the past year much progress in tuberculosis rehabilitation has been made. Tuberculosis associations, aware that post-discharge rehabilitation work covers only a portion of the potential field, have been adjusting and enlarging their programs to demonstrate the advisability of bringing the program to the patient while he is in the sanatorium.

There have been several meetings of a group committee, called together by Dr. Mahaffey, for study of the problem of recalcitrant tuberculosis patients, a number of whom are located throughout the various counties of the State. The late lamented Commissioner Ellis of the Department of Institutions and Agencies was deeply interested in this matter, and was instrumental in the progress which has been made. Legislation now under consideration, which would permit the commitment of recalcitrant patients to a specially designated sanatorium for treatment, can be expected to solve a major part of the problem.

## VENEREAL DISEASE CONTROL

Baxter A. Livengood, M.D., Chairman, Woodbury

The Advisory Committee on Venereal Disease Control during the year adopted for its program:

First, the promotion of an educational program on the newer treatments of gonorrhea and syphilis, the value of penicillin and its public health application. In coöperation with the Bureau of Venereal Disease Control of the State Department of Health we were able to arrange a speaker on one of the monthly programs of the majority of all the County Societies of the State, which helped to bring the best information to date directly to the private physicians and increase the effectiveness of treatment.

Second, the promotion of the formation of a new organization known as the Association of Venereal Disease Clinic Physicians which includes the physicians of the various Venereal Disease Clinics throughout the State, which have existed for a number of years doing a very valuable part of V. D. Control. The purpose of the association is to promote the welfare of these clinics.

Third, the approval of the revision of our State Venereal Disease Laws. Reference is made to Senate Bills S-11, S-12, and S-13.

The Advisory Committee feels that there has been definite progress made in these efforts.

# APPROVED AGENCIES

## MEDICAL SERVICE ADMINISTRATION OF NEW JERSEY
## MEDICAL-SURGICAL PLAN OF NEW JERSEY

These two organizations are non-profit medical service corporations organized by the Society under the provisions of Chapter I, Title 5 of the Revised Statutes for the purpose of operating non-profit medical service plans under the provisions of Chapter 48-A, Title 17 of the Revised Statutes.

All Plans operated by these organizations are designed to meet local needs in New Jersey and are in accordance with principles and policies approved by the Society. They provide for free choice of physician, non-interference in patient-physician relationship and payment for physicians' services on a fee for service basis.

### MEDICAL SERVICE ADMINISTRATION OF NEW JERSEY

Medical Service Administration, organized in 1939, studies the medical care distribution problems of the indigent and medically indigent groups of New Jersey and evolves Plans to meet the needs of these groups. We concede that if the medical care of these groups is to be paid for it will require tax money subsidies. At present the Administration is operating the following Plans:

#### *The City of Newark Medical Plan*

This Plan operates in accordance with an informal Memorandum of Understanding between the Administration and the City of Newark as represented by the City Department of Health and the City Department of Welfare. The Memorandum of Understanding, signed by representatives of the three agencies involved, allows for evolutionary changes and adjustments necessary to meet unforseen contingencies. It has brought about a most cordial and coöperative relationship among the three agencies, which has resulted in a very satisfactory solution of the problem in Newark. We believe such an arrangement is applicable on a state-wide basis.

The Plan, as applied to those persons whose names appear on the welfare rolls of the City, has been in operation since November, 1943. This is our first opportunity, therefore, to report on a full year's experience. The Plan provides for free choice of physician for the care of those persons whose names appear on the welfare rolls and who are confined to their homes because of illness. Each family has a card identifying them as eligible for this service and a memorandum of instructions to their physician. The attending physician submits his bill to the office of the Administration, where it is subject to approval, or adjustment after communication with the physician, and final approval by the Advisory Committee of Essex County Medical Society. To date every service approved by the Administration and forwarded to the City for payment has been paid for. The City pays the Administration at monthly intervals in the form of one check. In addition to the amount billed the City 10 per cent of the bill is added toward payment of administrative costs. Physicians' fees are $2.00 per day house call and $3.00 per house call made after 8:00 p. m.

In commenting on the Plan in a recent communication, the Director of Relief states: "I am happy to report that the Plan is very satisfactory, and we have had no difficulties whatsoever. It is a very practical method of meeting the needs of the medically indigent that are on our relief rolls, and I think the results speak for themselves."

The number of persons on the welfare rolls of the City during the year 1944 was reduced from 2871 in January to 1791 in December, for an estimated mean of 2082.

The per capita cost for medical care rendered under the Plan during the year was as follows:

| | |
|---|---|
| Mean Number of Persons | 2082 |
| Cost per person per year | $0.95 |
| Cost per person per month | 0.08 |

In January, 1944, at the request of the City of Newark, the Plan was extended to include the medically indigent of Newark as distinct from the indigent. Medical indigency is determined by the Newark Department of Health, and payment for the medical care rendered these persons is made directly to the Administration by the City of Newark without State aid.

During 1944, 435 families were defined as medically indigent, and in these families 519 persons received treatment.

These 435 families do not include all medically indigent families of Newark. They rep-

resent only those families who when applying for medical care were defined as medically indigent by the Department of Health. Therefore, it is not possible to estimate costs on a per capita basis of all medically indigent families in Newark. The following costs are based upon the number of families actually receiving care under the Plan.

| | |
|---|---|
| Number of Families Involved | 435 |
| Number of Persons Treated | 519 |
| Cost per family per month | $0.24 |
| Cost per person per month | 0.20 |

The total cost to the City of Newark for these medically indigent families was $1260.00 plus 10 per cent allowed the Administration toward administrative costs.

*Farm Security Administration Medical Plan*

We have operated this Plan for four years. It is sponsored by the Farm Security Administration of the Federal Department of Agriculture as part of their rehabilitation program for low income farm families. These farm families are without assets upon which to borrow money, and who, in the opinion of the federal government, are worthy of rehabilitation. Upon being granted a federal loan these families are placed upon a strict budget, their farm activities are placed under the supervision of experts and the government retains a lien upon all income from the farm. We are told that to date 80 per cent of money loaned to these farmers has already been repaid to the government.

Participation in the Medical Plan is voluntary. About 50 per cent of eligible families participate. Each participating farmer pays his subscription in advance by check on his personal bank account on an annual basis. Government checks, paid directly to the Administration, are not accepted. The Plan provides payment for the services of general practitioners rendered in the homes of the families or offices of physicians. It does not provide for hospital expenses or the services of physicians rendered in hospitals. The subscription rate is $16.00 to $24.00 per year per family, depending upon the size of the family. The fee schedule is $1.50 per office call and $2.50 per house call.

The Plan has very definitely been of great assistance to these families. It meets their greatest medical care need by making early medical care available, providing for early diagnosis, health guidance, and the treatment of the many minor illnesses experienced by farm families. It has been of particular advantage to children.

There is a high incidence of illness among this group. In visiting these families one is impressed by the prevalence of defects and deformities among them. It seems more correct to say that their low economic status is due to physical defects rather than to say that their physical defects are due to low income. The main defects in the Plan are due to its limitations. These families should have a complete program, including costs of hospitalization and costs of physicians' services rendered in hospital. It would not be practical to estimate the cost of such a complete program for this particular group and their income would not support such a Plan. The obvious solution is a Plan paid for in whole or in part by government subsidy.

The coöperation of Farm Security representatives in the State has been excellent. We recommend that the Plan be continued providing a satisfactory enrollment is maintained. It does, at least partly, fill a need. It does improve medical care distribution. It does illustrate the willingness of organized medicine to coöperate with government where the need is shown. It does provide an income to the profession at the rate of $4600 per year per thousand families, and while this income is not adequate, it does provide an income which would not otherwise be available.

The experience of the Plan for the twelve calendar months of 1944 was as follows:

| | |
|---|---|
| Mean Number of Families | 395 |
| Mean Number of Persons | 1,677 |
| Total Subscription Income 1944 (after 10% deducted toward administration costs) | $8,187.00 |
| Total Claim Costs, as paid, 1944 | 7,760.96 |

| | Per Family | Per Person |
|---|---|---|
| Annual Subscription Income | $20.72 | $4.88 |
| Annual Claim Costs, as paid | 19.64 | 4.63 |
| Monthly Subscription Income | 1.73 | 0.41 |
| Monthly Claim Costs, as paid | 1.64 | 0.39 |

| | |
|---|---|
| Reserve in Farm Security Account Dec. 31, 1943 | $560.30 |
| Reserve in Farm Security Account Dec. 31, 1944 | 774.62 |
| Increase in Reserve 1944 | $214.32 |

During the year it was necessary to pro-rate physicians' fees on three occasions, as follows:

March—25% deducted for all visits
July—10% deducted for all but single visit cases
October—20% deducted for all but single visit cases

The money deducted totalled $371.31. Therefore, had all calls been paid for in accordance

with the schedule of fees, the Plan would have experienced a deficit for the year of $156.99 rather than a gain in reserve of $214.33.

## MEDICAL-SURGICAL PLAN OF NEW JERSEY

Medical-Surgical Plan was incorporated in 1942, and as approved by the House of Delegates has been operating for two years and eight months as of February 28, 1945.

The Plan is designed to assist self-supporting employed persons when overtaken with serious or catastrophic illnesses. Its benefits are eligible for payment for services rendered by fully licensed physicians to its subscribers and their enrolled dependents while bed patients in approved hospitals. Medical, surgical, obstetrical, anesthesia and consulting services comprise the eligible services under the contract. Its benefits are not eligible for payment for services rendered prior to hospital admission or after hospital discharge.

The original contract of the Plan provides that Participating Physicians deem as payment in full the amounts payable by the Plan providing the patient is admitted to hospital for ward or semi-private accommodations, and that if the patient is admitted for private room (one bed per room) accommodations the amount payable by the Plan may be considered by the Participating Physician as a credit toward his entire fee, any additional amount being a responsibility of the subscriber.

The old contract was, in the opinion of the Board, a sound arrangement. Under its provisions 15 per cent of patients have been admitted for private room accommodations. This 15 per cent parallels the 15 per cent of New Jersey families reported to have had incomes of over $3000 in 1942. There have been some abuses of the contract among persons of ample income, and it has been difficult for physicians to control the type of accommodations to which their patients were admitted. It has been difficult to educate physicians as to the provisions and advantages of the old contract. Under its provisions the Plan has paid in fees 80 per cent of all money billed to the Plan by physicians, which we think is a fair parallel to the collection rate of the profession in normal times. About 28,000 persons are covered by this contract, which is effective until the termination date of each individual contract. They will be replaced upon their date of expiration by our new contract, but this process will not be completed until December, 1945.

The profession has expressed a demand for a contract providing that Participating Physicians may make a charge in addition to the amount payable by the Plan for services rendered persons of higher income groups. To accomplish this it was necessary to amend the Statute under which the Plan operates. This amendment was accomplished in April, 1944, as reported to the House of Delegates last year. On the basis of this amendment, and to correct other defects demonstrated by the Plan's experience, a new contract has been evolved which has been issued to all persons subscribing to the Plan since January 1, 1945.

To promote mutual understanding we quote in its entirety the Section of the new contract providing for credit payments.

"Section V. When Plan Payment Is Not in Full for Eligible Medical and Surgical Services:

Payment by the Plan shall not be deemed to be in full for medical and surgical services eligible for payment under this contract:

(1) If the patient shall have been admitted for a private accommodation, not exceeding one bed per room; or

(2) If the patient (otherwise than at the instance of the hospital or physician) shall have transferred to such private accommodation after having been admitted for either a semi-private or ward accommodation; or

(3) If the patient shall have been admitted for a semi-private or ward accommodation but shall have agreed to pay the Participating Physician an amount in addition to that payable by the Plan, except that no such additional amount shall be payable to the Participating Physician if, for the twelve calendar months immediately preceding the month in which the hospital admission for the medical and surgical services occurs, the income of the subscriber, enrolled under a Single Contract, is less than $2,000; or the income of the subscriber, enrolled under a Family Contract, is less than $2,000 plus $500 for the first enrolled dependent (wife [husband] or child) plus $250 for each additional enrolled dependent; or

(4) If the patient shall have been admitted for any type of accommodation and shall have been attended by a duly licensed physician who is not a Participating Physician; or

(5) If the patient shall have been admitted for a semi-private or ward accommodation but shall have failed to disclose to the Participating Physician the existence of this contract prior to such physician's agreement to render the medical and/or surgical services, except that no additional amount shall be payable to the Participating Physician if the income of the subscriber is less than as stated in Section V (3).

In any cases to which any of the above five subparagraphs of this Section may apply, the only benefit available under this contract (toward, but not in excess of, the physician's charges to the patient for such eligible medical and surgical services) shall be payment by the Plan of the amount then payable by it to Participating Physicians for such services, and the Plan shall not be liable for any balance."

### ENROLLMENT

As of February 28, 1945, 33,107 persons were enrolled, of which 14,683 were subscribers and 18,424 were family dependents. This is an increase of 14,027 persons during the preceding 12-month period. The Plan, in the past, has not been anxious to expand rapidly. We have tried to maintain a steady, progressive increase of about 1000 persons a month. In this way we have been able to study our problems, develop administrative methods, and correct defects without unduly disrupting medical economics or appreciably affecting the income of any physician. Now that our estimates have been proven reasonably correct we are in a position to expand the Plan more rapidly. It must be greatly expanded if it is to meet the needs in New Jersey.

There was some variation on a monthly basis during the year, but it never fell below 66 cents. Assuming the income per person becomes stabilized at 67 cents, and assuming further that all persons in New Jersey were enrolled as under a Wagner Bill Plan and that 4500 physicians are in private practice in New Jersey, the income per physician, less administrative costs of the Plan, is shown below.

This estimated income per physician of $7,140.00 per year for services rendered in hospital compares to the estimated income per physician of $5000 for services rendered in hospital, patients' homes, and physicians' offices under the type of Plan provided by the Wagner Bill.

In evolving a solution of our problem we must think at present in terms of over-all income to the profession. We must maintain an adequate over-all income though we cannot give assurance of maintaining what is considered an adequate fee for service in individual cases. This is because of the unknown factors of disease incidence and the incidence of surgical procedures found necessary in our enrolled groups. It is now apparent that a considerable number of employed persons have in the past denied themselves adequate medical care because of costs, as evidenced by our hospital admission rate as compared to the normal hospital admission rate. If the profession is willing to care for the unknown number of preëxisting conditions in our enrolled groups, on the basis of an assured adequate over-all income, the fee for service for individual cases will eventually improve as the clinical load is decreased. This is the problem facing the profession. Medical-Surgical Plan is your agency, to assist you in the solution of this problem.

The Plan now has about 3500 Participating

A SUMMARY OF THE PLAN'S EXPERIENCE

| | Earned Income | Accrued Claims | Per Cent of Income | Operating Expenses | Per Cent of Income | Earned Reserve | Per Cent of Income |
|---|---|---|---|---|---|---|---|
| July 1-Dec. 31, 1942... | $ 11,148.78 | $ 5,394.50 | 48.3 | $ 5,702.94 | 51.1 | $ 51.34 | 0.67 |
| Calendar Year 1943... | 74,498.47 | 49,562.50 | 66.5 | 17,785.96 | 23.9 | 7,150.01 | 9.6 |
| Calendar Year 1944... | 187,708.74 | 135,605.75 | 72.2 | 35,504.03 | 18.9 | 16,598.96 | 8.9 |
| Jan. 1-Feb. 28, 1945... | 40,917.82 | 24,146.30 | 59. | 7,655.99 | 18.7 | 9,115.53 | 22.3 |
| Totals ..... | $314,273.81 | $214,709.05 | 68.3% | $66,648.92 | 21.2% | $32,915.84 | 10.5% |

FINANCIAL RESERVES OF THE PLAN

| | |
|---|---|
| Unencumbered Earned Surplus ..... | $28,478.05 |
| Capital Fund donated by Society in 1942 ..... | 5,000.00 |
| Contingency Legal Reserve ... ..... | 4,437.79 |
| | $37,915.84 |

The contingency reserve, consisting of 2 per cent of income earned after the first year of operation, is required by law.

In addition to the above $37,915.84 there is set aside as a liability, $10,000, to cover the estimated cost of unreported cases.

### ADMISSION RATE

Hospital admissions during the year 1944 were at the rate of 91 persons per thousand per year. This compares to the normal rate in New Jersey of 77 per thousand per year. This difference of 14 points we believe represents persons who obtained adequate hospital and medical care under the contract of Hospital Service Plan and the contract of Medical-Surgical Plan who would not have received it otherwise because of costs.

### INCOME TO THE PROFESSION

The income of the Plan during 1944 per person enrolled was about 67 cents per month.

| Population | | Monthly Income per Person | | Monthly Income of Plan | | Number of Physicians | | Per Physician per Month | Per Physician per Year |
|---|---|---|---|---|---|---|---|---|---|
| 4,000,000 | x | .67 | = | $2,680,000 | ÷ | 4500 | = | $595.00 | $7,140.00 |

Physicians, representing at least 51 per cent of the fully licensed physicians practicing in 20 of our 21 counties. The Plan is now licensed to operate in these 20 counties. The only county in which the Plan is not licensed is Atlantic County.

We believe the Plan is financially sound. We believe it represents the proper approach to a correct solution of the problem of employed persons of New Jersey. It is controlled by the profession and will be maintained under control of the profession, in accordance with policies and principles approved by The Medical Society of New Jersey. It is evolutionary. It is yours. We will welcome your suggestions and constructive criticisms.

In this report we are not commenting on the national picture or trends. We believe such a report is within the scope of committees within the Society.

## STATE BOARD OF MEDICAL EXAMINERS OF NEW JERSEY

E. S. HALLINGER, M.D., F.A.C.S., Secretary, Camden

During the period of January to December, 1944, the Board examined one hundred and eighteen applicants for a license to practice medicine and surgery. Thirty-one of the applicants were graduates of osteopathic colleges.

The Board also examined ten applicants for a license to practice chiropody.

One hundred and fifty-nine licenses were issued to applicants for endorsement of a license from another state who presented credentials to prove they could meet the requirements for examination that were in force in New Jersey at the time they were examined.

All credentials covering medical and hospital work submitted to the Board were verified by questionnaires sent to the colleges and hospitals in this country before a license was issued.

The laws governing the practice of medicine and surgery, osteopathy and chiropractic, do not provide for an annual registration. The Board does not, therefore, know whether the number of licentiates in the State now in practice is increasing or decreasing.

Annual registration would give the Board accurate information in regard to the number of physicians practicing in New Jersey and would enable the licensed physicians to assist the Board in enforcing the law by reporting unlicensed physicians in their vicinity.

The laws governing the practice of chiropody and midwifery do provide for an annual registration and our records show a decrease of one in the number of chiropodists registered on November 1st, 1944, and a decrease of eighteen midwives for the same period.

TABLE I—SHOWING NUMBER OF CANDIDATES FOR THE 1944 EXAMINATIONS, CLASSIFIED AS GRADUATES OF MEDICAL COLLEGES IN THE UNITED STATES AND FOREIGN COUNTRIES AND ACCORDING TO CITIZENSHIP

| | Citizens | *Non-citizens | Total | Passed | Failed |
|---|---|---|---|---|---|
| MEDICAL | | | | | |
| *United States* | | | | | |
| Graduates of Medical Schools | 57 | | 57 | 57 | |
| Osteopaths Who Qualified for a Full License to Practice Medicine and Surgery | 31 | | 31 | 30 | 1 |
| Canada | 1 | | 1 | 1 | |
| Italy | 16 | | 16 | 8 | 8 |
| Austria | 2 | | 2 | 2 | |
| Germany | 2 | 1 | 3 | 1 | 2 |
| Hungary | 3 | | 3 | 2 | 1 |
| Switzerland | 3 | | 3 | 2 | 1 |
| Czechoslovakia | 2 | | 2 | 1 | 1 |
| CHIROPODY | | | | | |
| United States | 10 | | 10 | 10 | |
| | 127 | 1 | 128 | 114 | 14 |

*Those who were non-citizens had taken the examination prior to the passage of the amendment requiring full citizenship and failed and were entitled to reëxamination. They submitted Declaration of Intention to become a citizen of the United States and were granted a license valid for six years from Date of Declaration.

TABLE II—*Showing Licentiates by Endorsement Classified as Graduates of Colleges in the United States and Foreign Countries*

| | |
|---|---|
| United States | 104 |
| Canada | 4 |
| Great Britain | 8 |
| Austria | 8 |
| Germany | 13 |
| Italy | 3 |
| Hungary | 3 |
| France | 2 |
| Switzerland | 8 |
| Czechoslovakia | 5 |
| Iraq | 1 |
| | 159 |

TABLE III—*Showing Number of Physicians and Surgeons, Osteopaths and Chiropractors Endorsed to Other States, the Number of Licentiates of Whose Death the Board Received a Report and the Number of Licenses Revoked.*

| | |
|---|---|
| Physicians—Endorsed to Other States | 13 |
| Osteopaths—Endorsed to Other States | 8 |
| Chiropractors—Endorsed to Other States | 1 |
| Medical—Licenses Revoked | 2 |
| Medical—Licenses Restored | 1 |
| Medical—Reinstatement Petition Pending | 1 |
| Physicians—Deceased | 57 |
| Osteopaths—Deceased | 2 |
| Chiropractors—Deceased | 1 |
| | 86 |

## ENFORCEMENT

A brief report of the Board's activities in enforcing the laws it administers follows:

*Court Cases—Violation of Medical, Etc., Laws*

| | | |
|---|---|---|
| Convicted, Pleaded Guilty or Settled | 22 | |
| Lost, No Appeal | 2 | |
| No Service | 2 | |
| Pending in the Courts | 13 | |
| Discontinued by Board | 1 | |
| Chiropodists—Failure to Register | 1 | |
| | | 41 |

*Cases—Supreme Court*

| | | |
|---|---|---|
| Won by Board—Appeal to Supreme Court as Defendant was convicted of a First Offense and Board was Suing for Second Offense—Decision in Favor of Board | 1 | |
| Won by Board—Appeal to Supreme Court by Defendant—Judgment of Trial Court Sustained—Defendant Appealed to Court of Errors and Appeals and Decision of Supreme Court Was Affirmed | 1 | |
| Writ of Mandamus Taken to Supreme Court to Compel Board to Admit a Graduate of a Non-recognized Medical School to the Examination—Application Denied | 1 | |
| | | 3 |

*Hearings Before Board*

| | | |
|---|---|---|
| Medical—Licenses Revoked | 2 | |
| Medical—Licenses Restored | 1 | |
| Medical—Reinstatement Petition Pending | 1 | |
| | | 4 |

## CLASSIFICATION OF INVESTIGATIONS AND INSPECTIONS

| | |
|---|---|
| Druggists Practicing Medicine | 24 |
| Prescribing Herbs and Drugs | 22 |
| Unlicensed Medical Doctors | 17 |
| Unlicensed Chiropractors | 44 |
| Licensed Chiropractors Exceeding License | 5 |
| Unlicensed Osteopaths | 1 |
| Licensed Osteopaths Exceeding License | 4 |
| Unlicensed Chiropodists | 6 |
| Masseurs and Massage Treatments | 8 |
| Naturopaths | 9 |
| Physio-Therapists | 6 |
| Laying-on-of-Hands | 1 |
| Medical—Revocation | 2 |
| Licensed Chiropodists Practicing Chiropody After Failure to Register | 1 |
| Nurse Practicing Medicine | 1 |
| Spiritualists | 1 |
| Electro-Therapists | 1 |
| Miscellaneous | 4 |
| | 157 |

## ANALYSIS OF INSPECTIONS AND INVESTIGATIONS

| | |
|---|---|
| Total Number of Investigations and Inspections Made | 157 |
| Total Number of Visits Made and Treatments Received in Making the Investigations and Inspections | 931 |
| Average Number of Visits per Investigation | 5.9 |

## LEGISLATION

Section 45:9-8 of Title 45, Chapter 9, Article 1, of the Revised Statutes of New Jersey, was amended in 1944 to provide that the Board may in its discretion, during the present war emergency and for a period of three months thereafter, admit an applicant to licensure who has completed not less than nine months of an internship acceptable to the Board in an approved hospital. The same section of the law pertaining to certifying prospective internes to hospitals situated in New Jersey for interne training was repealed.

Section 45:9-16 of the same Title, Chapter and Article, was amended to provide that anyone who pleads nolo contendere, non vult contendere or non vult to an indictment is subject to revocation or suspension of his license.

The same section was amended to provide that the payment of a penalty or any part thereof for any alleged violation of Chapter 9 of Title 45 of the Revised Statutes, either before or after the institution of proceedings for the collection thereof, shall be deemed equivalent to a conviction of the violation for which such penalty was claimed.

Section 45:9-21 was amended to provide that a chiropodist may give certain treatments while operating in each particular case under the specific direction of a regularly licensed physician or surgeon.

# COUNTY SOCIETIES

## ATLANTIC

Charles Hyman, M.D., President, Atlantic City

The past year has been an unusually quiet one as far as local activities were concerned. The meetings were almost entirely scientific in character and the following were our speakers and their topics:

September, 1944—Dr. Frank W. Konzelman, Director of Laboratories, Atlantic City Hospital—"The Rôle of the Laboratory in the Diagnosis of Disease".

October—Dr. Henry B. Decker, Camden, Chief, Skin Clinic, Jefferson Hospital—"Common Skin Diseases".

November—Dr. Edward Weiss, Philadelphia, Clinical Professor of Medicine, Temple University — "Psychosomatic Aspects of Cardiovascular Disease".

December — Dr. John B. Montgomery, Philadelphia, Clinical Professor of Gynecology, Jefferson Hospital — "Functional Menstrual Disorders".

January, 1945—Col. Raymond A. Scott, Thomas England General Hospital, Atlantic City — "Objectives of Reconditioning".

February—Mr. W. Elmer Brown, Atlantic City — "The Lawyer Looks at the Doctor".

March—Dr. David A. Cooper, Philadelphia, Assistant Professor of Medicine, Graduate School, University of Pennsylvania—"Chemotherapeutic Advances in Tuberculosis".

April—Dr. W. E. Burnett, Philadelphia, Professor of Surgery, Temple University—"Recognition and Management of Surgical Diseases of the Abdomen".

Despite the difficult conditions under which all of our members were working a good attendance record was maintained.

## BERGEN

William K. Harryman, M.D., President, Hackensack

The work in our County Society during the past year has naturally been limited due to the war. We have undertaken no new projects, keeping the individual committees' work to the minimum. A number of excellent speakers have been heard at the regular monthly meetings and the attendance on the whole has been fair. Several times the weather interfered with our meetings.

The work of the individual men has been very satisfactory and I have found them most coöperative. We have had the opportunity of welcoming back several of our old members who have been discharged from the Service and also of admitting a number of new members, newcomers to the county. Our total membership, including the men in the Service, has been steadily growing, and taking everything else into consideration we have had a satisfactory year.

## BURLINGTON

Hammell P. Shipps, M.D., President, Delanco

In these days of war, with the depletion of our ranks on the home front, it has not been easy to carry on the program of the Medical Society.

Meetings, however, have been held regularly and the attendance has been remarkably good in proportion to those at home. Our county has a total membership of seventy-one, twenty-three of these have gone into the Armed Service, one of whom has been killed in action.

The scientific programs each month have been excellent. A number of outstanding spe-

cialists in various fields have taken part in these programs.

During the year nothing spectacular has been accomplished, but there has been remarkable loyalty on the part of our membership and this at a sacrifice of time and energy so badly needed in the carrying on of medical practice in a rural county in these days. More than the required 50 per cent of our membership has responded to the solicitations of our Insurance Committee and have subscribed to the Accident and Health policy recommended by the State Society, thus making the improved benefits available to our membership.

We have felt it was due an outstanding member of our Society, Dr. J. Howard Hornberger, that his name be proposed for Second Vice-President of our State Society. We are pleased that this recommendation has been so well received by other counties. We feel that Dr. Hornberger well deserves this honor and we are proud of the work that he has done, not only in our County Society, but in the work of our State.

We have taken an active interest in the work of the National Physicians Committee, and are supporting this work both individually and as a group. It has been our aim to make our Committee on Medical Service and Public Relations a strong and active one, believing that its work is tremendously important in these days of change.

## CAPE MAY

George M. Brooks, M.D., President, Cape May Court House

The past year has been a rather difficult one for our Society due to the fact that everyone has been so busy and that the membership is almost totally located in the northern and southern part of the county. It has been difficult for us to get together for regular meetings. We did, however, hold five meetings during the year, mostly for the purpose of routine business transactions. At the January meeting, the following officers were elected: President, Dr. George M. Brooks; Vice-President, Dr. J. S. C. Eisenhower, Jr.; Secretary, Dr. Marcia V. Smith; Treasurer, Dr. Frank R. Hughes.

Our last meeting was held at the Claridge Hotel in Atlantic City, N. J., on February 16, 1945. Prior to the meeting, the Society members, together with members of the Dental Society of Cape May County, made an inspection tour of the England General Hospital. This was most interesting and instructive. Several members of the Staff of the England General Hospital were guests of the Society at its dinner and meeting in the evening. These men gave some very interesting talks. We were glad to have members of the Cape May County Dental Society with us and I feel that such joint meetings would be mutually beneficial at other times.

## CUMBERLAND

Mary Bacon, M.D., President, Bridgeton

During the past year we have had the following speakers address the Society:

Dr. William Harvey Perkins—"Medicine, an Applied Science".

Dr. Temple Fay—"Neurological Lesions in Children".

Dr. James S. Shipman—"Ocular Injuries and Their Management".

Dr. Leandro M. Tocantins—"Practical Aspects of the Problem of Hemorrhagic Disease".

Dr. W. Emory Burnett—"Carcinoma of the Colon".

One new member has been added: Dr. Herbert P. Anastor, Vineland.

Dr. Alfred Cornwell of Bridgeton, after 50 years' membership in the County Society, has been made a Life-Member.

Dr. Frank R. Sheppard of Millville and Dr. Morton Guzy of Bridgeton have been taken from us by death; Dr. Barney Lihn lost his life in military service.

During the current year the County Society has accepted the Medical-Surgical Plan of New Jersey; and endorsed the Physicians' Group Accident and Health Insurance Plan approved by the State Society.

It is reported by Procurement and Assignment that fifteen of Cumberland County's sixty-five active members are now in military service.

Dr. Charles Sharp has been appointed Legislative Keyman of Cumberland County.

In the County we have thrifty, active clinics: "Orthopedic" in Bridgeton, Vineland and Millville Hospitals; "Venereal" in Bridgeton and Vineland; "Chest" in Bridgeton, Millville and Vineland; and "Tumor" in Millville. All these are approved by our Society, conducted monthly, and are well staffed and well attended.

Delegates were appointed to the neighboring counties of Camden, Gloucester, Cape May and Salem.

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## ESSEX

LOUIS SCHNEIDER, M.D., President, Newark

The Essex County Medical Society has had a very active and progressive year, and the coöperation of the various committees in making this possible has been splendid.

Our stated monthly meetings have offered a varied and interesting program. Speakers were as follows: October 12, 1944—E. M. Bluestone, M.D., "Chronic Disease Hospital"; November 9, 1944—Walter I. Lillie, M.D., "Fundal Changes of Arteriolar Hypertension"; December 14, 1944—Lt. Col. Oliver R. McCoy, M.C., "The Importance of Tropical Diseases in Returned Soldiers"; January 4, 1945—P. S. Pelouze, M.D., "New Methods of Treatment of Gonorrhea in the Private Practitioner's Office"; January 11, 1945—Maj. Donald Covalt, "Rehabilitation"; February 19, 1945—Robert H. Ivy, M.D., D.D.S., "Recent Advances in Plastic and Maxillo-Facial Surgery"; February 20, 1945—Norman M. Scott, M.D., "Experience of the Medical-Surgical Plan in Providing Voluntary Health Insurance"; March 8, 1945—Ernst P. Boas, M.D., "Social Problems Resulting from Chronic Illness and the Medical and Hospital Facilities Needed for Their Solution"; April 12, 1945—Capt. Lewis K. Ferguson, M.C., U.S.N.R., "War Surgery and Rehabilitation in the Navy."

A plan for the care of the indigent sick of the City of Newark has been carried through successfully this year, by appealing to the doctors of Newark to volunteer to do this work for a nominal fee.

Concentration of effort, however, has been on a larger and more inclusive program for the chronic sick of our County. It is our hope that the idea of the need for a hospital devoted to this problem has been firmly implanted and will gain strength in the months and years to come. Because—and I repeat what our speakers have said, and what statistics show—chronic disease is the major medical problem of our time. Contagious diseases have come under control, and as a result of longer life, chronic illness has come to the fore.

There is general agreement that the long-term patient needs a special type of care that is not at present afforded in our public institutions. It has therefore been our aim to bring before the public and before the officials of this county an awareness of this problem and a desire to do something to meet it.

Since many communities have found it advisable to convert their relatively unused isolation hospitals to this purpose, the suggestion was made that this might also be a solution for our community. Professional advice led us to understand that an 800-bed hospital would be sufficient to meet our needs. Potential facilities seem adequate.

The plan was not wholeheartedly received, but coöperation within the Society was good, and we trust that the main issue has not been forgotten in the light of disagreements on policy. These facts remain: We need some plan for our chronic sick, and it is up to the County to assume responsibility for, and give adequate care to, this large and apparently expanding group in our population.

We feel it is up to us in the Medical Society to assume responsibility for those of our membership who have been voluntarily removed from their normal course of achievement through service in the Armed Forces. We have no definite program yet in this connection, but will report progress.

## HUDSON

WALTER D. WEBER, M.D., President, Union City

The outstanding activities and accomplishments of the component society of Hudson during the past administrative year are as follows:

1. Eight regular monthly meetings, all well attended in consideration of present conditions, were held at the Masonic Club in Jersey City. For each meeting we were fortunate in obtaining a guest speaker considered an authority in his particular field. A spirited discussion from the floor, terminated by the speaker of the evening, followed each presentation.

2. Our Membership Committee announces the addition of seventeen new names to our roster, and the reinstatement of nine former members, making our Society stronger numerically than at any time since its inception. Three honorary memberships were conferred. We regret that death claimed eight members during the season now closing.

3. Our Medical Economics Committee, of which Dr. Londrigan consented to retain the chairmanship despite his responsibilities as State President, took the lead of all other committees in degree of activity. The particular interest of this committee continues to be the organized opposition to all forms of political medicine. The allocation of $3500 by the County Society to this Committee made possible a successful campaign of advertising in the four county newspapers, for the benefit of the lay public. Through this Committee, our Society has given practical assistance to the National Physicians Committee in its fight against socialized medicine.

As part of our local program and at the invitation of the Hudson County Dental Society, our Society collaborated with this group in welcoming to Jersey City on December 9, 1944, Dr. Morris Fishbein, a well-known antagonist in the field of political medicine.

4. In the interest of its members, and largely through the efforts of Dr. Andrew C. Ruoff, Chairman of the Accident and Health Insurance Committee, the Society of Hudson adopted the State Society Plan of Accident and Health Insurance as sponsored by the National Casualty Co., oversubscribing the 50 per cent enrollment requirement.

5. In coöperation with Dr. Norman M. Scott, Medical Director of Medical-Surgical Plan of New Jersey, a standing committee of our Society was designated as the intermediary between physicians participating in the Plan and representatives of the Plan. This committee functioned adequately and satisfactorily when needed.

6. Efforts have been directed toward the improvement of our monthly Bulletin, and a considerable amount of favorable comment has resulted. From a business point of view, the secretary's office has obtained advertising sufficient to defray the cost of the publication, with a margin of profit.

6. In integrating our diversified activities and accomplishments, we have endeavored at all times to safeguard and advance the interests of our fellow members serving in the Armed Forces, and have under consideration at this time a service for our discharged medical veterans.

In conclusion, may I add that this report would be incomplete were it not to mention the just pride of Hudson County Medical Society in having one of its members and a Past President, Dr. Joseph F. Londrigan, in the Presidency of The Medical Society of New Jersey at the present time. We feel that he is fulfilling the manifold duties of his office with credit to the County Society and with honor to the State Society.

## HUNTERDON

VLADIMIR F. CTIBOR, M.D., President, Califon

Meetings of the Hunterdon County Medical Society in the past year have been mainly limited to problems of local interest and those provoked by communications from the State Society.

The Annual Meeting of the Society on April 24, 1945, was addressed by Dr. P. S. Pelouze, Assistant Professor of Urology, University of Pennsylvania, on the subject of "The Diagnosis and Management of Gonorrhea".

It is to be sincerely hoped that the coming

year shall begin to herald the return of our absent members serving our country, and that they shall return to a system of medicine as free as the principles of freedom for which the men they have been caring for, are fighting. This has been the endeavor of their County Society in their absence. We have had a very satisfactory year.

## MERCER

Richard T. Buckley, Jr., M.D., President, Hightstown

Mercer County may indeed feel justly proud of the accomplishments recorded during the past year.

We are greatly indebted to our Program Committee which has efficiently provided us with scientific subjects presented by outstanding authorities from our several Universities of Medicine.

The following list gives some idea of the diversity of the phases of Medicine and Surgery discussed:

"Evaluation of the Diagnostic Procedures and Therapy in Peripheral Vascular Disease."

"Hypertensive Retinopathy."

"Some Problems in Fractures."

"Diagnosis and Treatment of Hay Fever."

"The Transplantation of Skin."

"Discussion on Penicillin for Syphilis and Gonorrhea."

The Wagner-Murray-Dingell Bill received considerable attention with final emphasis being placed upon the necessity of a far-reaching substitute to be realized in the Medical Service Administration Plans, Hospitalization and Medical-Surgical Plans.

The Society discussed the activities of the National Physicians Committee and unanimously decided to record approval and support of the Committee.

The Mercer County Society has at all times supported the "Cancer Control Campaigns", and in the past year has provided further activity by the appointment of representative members who have shown considerable enthusiasm and active participation in public gatherings.

The approval of an expression from the Society of unstinted coöperation in the work of the Women's Field Army, apparently received the appreciation of that organization.

The Speakers' Bureau continues to function; however, there appears a lack of sufficient publicity in arousing encouraging attendance to support the effort of our listed speakers.

Continued support of our Legislative Committee is manifested in the attendance recorded during the special hearings before our State Legislative Committees.

The appointment of a Food Panel to work in conjunction with the O. P. A. cast another burden upon our representatives; however, the members are serving willingly and display evidence of a spirit of hearty coöperation.

Perhaps the outstanding accomplishment, aside from our scientific studies, was the promulgation, at the suggestion of City Welfare Agencies, of the Emerson Survey.

The Survey covered an extensive administrative area of Health Welfare activities within the County of Mercer and produced a volume of illuminating facts and figures, all of which has tended to activate a complacent lethargy, which is manifested in recent public expression of guarded approval.

The Committee of the Mercer County Society, appointed to study and submit recommendations relative to certain apparent drastic changes in policies recorded in the survey, rendered a report which was unanimously approved.

I desire to express my sincere appreciation of the untiring effort displayed by the several Committees with whom it has been my pleasure and privilege to associate in advancing the front-line of scientific progressive medicine and all health welfare projects.

## MIDDLESEX

W. Edgar Sherman, M.D., President, New Brunswick

True to its tradition, the Middlesex County Medical Society has carried on despite the difficulties of a decreased personnel and an increased burden of private practice on those doctors remaining at home.

The monthly meetings are being held regu-

larly, and have been fairly well attended, despite bad weather conditions prevailing on most meeting nights. However, there will probably always be room for improvement in the attendance at these meetings.

The Program Committee, Dr. Edward F. Klein, Chairman, presented very fine speakers.

Speakers were provided by the Speakers' Bureau to talk on the Wagner-Murray-Dingell Bill.

The outstanding event of the year was the Testimonial Dinner given for six members who have been practicing for more than half a century. The members honored were: Drs. G. T. Applegate, New Brunswick; C. B. Burnett, South River; Frank C. Henry, Sr., John L. Lund and G. W. Tyrrell, Perth Amboy, and Ira T. Spencer of Woodbridge. Gold 50-year pins bearing the numerals "50" and the caduceus were presented to the members honored. The Hon. John A. Matthews of Newark, Advisory Master of the Court of Chancery, was the guest speaker. Invited guests were Mayor J. A. Delaney of Perth Amboy, Mayor Chester Paulus of New Brunswick, Mayor M. A. Maliszewski of South River and Mayor A. F. Greiner of Woodbridge; officers of the Ladies' Auxiliary. Invocation was given by Dr. William H. S. Demarest; prayer for the 60 members in Armed Service was given by Rev. Francis P. J. Coan; and Rabbi N. M. Keller pronounced the benediction. Dr. Henry Haywood, Chairman of the Committee of Arrangements, was Toastmaster.

## MONMOUTH

Otto R. Holters, M.D., President, Asbury Park

During the past year the activities of the Society have been maintained at a high level despite all the difficulties imposed by war-time conditions and the absence of more than 50 per cent of our members.

The meetings have been well attended and interesting programs were arranged for each meeting; most of them were highlighted by some outstanding out-of-town speaker.

The Society was shocked to learn of the death of Dr. Edmund Kanses, formerly of Rumsen, N. J., who was killed in action during the Normandy invasion. In memory of his heroic sacrifice the Society has inaugurated a memorial fund dedicated to the assistance of returning physicians from the various war fronts.

The Woman's Auxiliary was revitalized and now meets on the average of once a month.

As the result of a resolution passed by the County Society the Woman's Auxiliary will undertake to create a blood donors' service, primarily for our indigent sick in the several hospitals of this county.

## MORRIS

F. Clyde Bowers, M.D., President, Mendham

Morris County held meetings in October, 1944; January and March, 1945, and will hold its annual meeting in June. These sessions were fairly well attended and were held in the various hospitals in the county. The programs were presented by the respective staff of each hospital. Anterior poliomyelitis was the subject discussed at Memorial Hospital in Morristown in October with the presentation of some twenty-odd cases. In January at Dover General a symposium on industrial medicine was well received. At All Souls in Morristown in March the subject was "Tumors of the Breast as Seen in Morris County".

Representatives from Morris have been active in the State Society. In addition to Drs. Young and Costello, members of Board of Trustees, our Secretary, Dr. Teskey, and former President, Dr. Teller, have been actively interested in the State Welfare Committee. Our legislative keyman, Dr. Comeau, has been keeping abreast of the medical legislation in our state.

Morris County is now in the midst of a campaign to get sufficient members enrolled in the special health and accident insurance scheme as recommended by the State Society and we expect to reach our quota.

Proposed changes to our constitution and by-laws have been recommended and will be voted upon at our June meeting. These have not been revised since 1929.

Also under consideration for the past year has been the establishment of an emergency fund for those members who might find themselves in need of financial aid. It is hoped that a concrete plan may be offered and adopted at the next meeting.

During the past year our society has lost four members to Divine Providence. Dr. Wilbur Judd, our County Reporter at the time of his death, was long associated with Greystone Park Hospital. Dr. Anna Allaben was the first woman physician to be licensed to practice medicine in Morristown. A former President of our society and always very active in its affairs, Dr. Erwin McElroy died in the prime of life in March. Also in the same month, Dr. Kinkead, young woman physician in Madison, passed away very suddenly. Morris County feels a deep loss by the death of these members.

In closing, our forty-five members in the Armed Forces are scattered about the globe. We are proud of each and every one of them and look forward to their speedy and safe return.

## SOMERSET

SAMUEL H. POGOLOFF, M.D., President, Manville

The highlights in the activities of the Somerset County Medical Society during the past year were as follows:

The annual dinner of the Society, in spite of the busy time, was well attended. After a short business meeting a good meal was served followed by a magician-entertainer.

A luncheon conference was arranged, the purpose of which was a get-together of the legislators of the County and the legislative representatives of the State Society.

Through the personal efforts of Dr. Londrigan, the State President, the County Society has approved the Medical-Surgical Plan of New Jersey.

Contact with the various "health-minded" clubs was kept up by the President and Public Relations Committee.

The influx of thousands of itinerant workers, particularly those imported from Jamaica and Puerto Rico, has increased the problems of the Public Health Committee.

The President and Past-President Field were present at the "Chiropractic Bill" hearings at Trenton.

The business meetings were held punctually, adding new members and discussing problems affecting doctors.

The scientific meetings were held with up-to-date topics, such as "Diagnosis and Treatment of Tropical Diseases".

Special meetings were held as the occasion demanded.

The Society is ever mindful of the doctor in the armed forces and giving all possible aid and encouragement to the discharged medical man.

## SUSSEX

JOHN E. LONGNECKER, JR., M.D., President, Sparta

The past year has been one in which medical activity has been concerned almost entirely with the care of the sick and little else.

Since the adoption of the new constitution, our meetings have been devoted to the presentation of interesting cases at combined hospital staff and Medical Society meetings. A medical committee which presented the problem to the Sussex County Freeholders has evolved a plan whereby contagion cases requiring hospitalization can secure it at Morristown.

The news from our members in the Armed Services has been most encouraging and we hope that on their return they will find the status quo being maintained. This has been our objective.

## UNION

M. G. Bensley, M.D., President, Summit

Several of our members addressed various groups on the Wagner Bill and a number of well-known organizations have requested material on the bill in order to discuss it before their own groups.

In spite of the fact that so many of our members are in the armed forces and all members at home are very busy, we have had a good attendance and all regular meetings have been held on schedule. Our Scientific Committee has provided very worthwhile programs of diversified interest.

The Chairman of the Legislative Committee, accompanied by several officers of the Society, attended one of the sessions in Trenton on the Chiropractic bill.

Due to increased membership and requests from many State and County Societies, hospitals and allied professions, the publication of the Bulletin has been increased to five hundred copies per issue. The Publication Committee is pleased to note this interest in the activities of the Society and also to hear from the doctors that the Bulletin very often helps them contact their colleagues in the armed forces.

The new non-cancellable group plan of accident and health insurance as approved by the State Society has been taken up this year.

Fifteen doctors volunteered to serve on the roster for emergency night calls in Elizabeth and these calls will be taken care of through the local police department.

A committee has been appointed to study the need for a County Hospital for the chronically ill after the war.

The Society is coöperating with the Union County Mosquito Commission's program to try to locate and eradicate malaria cases in this county. The work of the Commission has been increased due to the number of returned servicemen from the Pacific area who may have malaria or may be carriers.

The requests from lay organizations, coöperation with war-connected groups and assistance to the profession in many ways has made this a busy year for the Executive Staff. The routine work remains the same — correspondence, filing, mimeographing, bookkeeping, keeping all records up-to-date and managing the Medical Service Bureau.

One hundred and five meetings were attended by the Executive Secretary as the representative of the Society and we feel there is a better understanding between the medical profession and other professions and business.

We now have 135 members in service; six members have returned home after serving in the armed forces, and two members, Captain Edward J. Hackett and Captain Orrin F. Crankshaw, were killed in action. We have a total membership of 403 members.

## WARREN

Herman Baldauf, Jr., M.D., President, Belvidere

The Warren County Medical Society conducted its regular scheduled meetings with the exception of the January meeting which was postponed until April because of a snow storm. The meetings were routine.

The Society had but one speaker, Dr. Arthur C. Zuck, psychiatrist, Washington, who read an interesting paper on "Juvenile Delinquency." The Woman's Auxiliary was invited to hear the paper.

A committee composed of Drs. Arthur C. Zuck, William H. Varney, Floyd A. Shimer, Harry B. Bossard and Herman Baldauf attended a chiropractic hearing held at the State House in Trenton, in response to a call from the State Society.

The officers of our Society are elected at the annual meeting in October and now take office at the time of the Annual Meeting of The Medical Society of New Jersey. Heretofore the officers assumed office as soon as they were elected. Due to a misunderstanding correspondence is being sent to the newly elected officers before their term begins, which has caused quite some inconvenience. We trust this will clarify our arrangement.

Volume 42
Number 5



# Tuberculosis Abstracts

*A Review for Physicians*

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

**Vol. XVIII** **May, 1945** **No. 5**

ONCE established in the human body, the tubercle bacillus is capable of attacking at many places. Infection of the kidneys, while not uncommon, is often overlooked in its early stages. Partly, this must be blamed on the paucity of symptoms, partly on the fact that renal involvement is usually associated with more obvious disease in other organs, particularly the lungs.

It is well to be reminded of the symptoms, signs and laboratory findings which should lead one to suspect renal tuberculosis. Once the question is raised, there must be an exhaustive search of the patient for evidence that will confirm or allay the suspicion.

## EXTRARENAL LESIONS ASSOCIATED WITH RENAL TUBERCULOSIS

Renal tuberculosis is too often symptomatically silent during the time when it can be treated most successfully. The diagnosis of this condition can be made most satisfactorily by the identification of the organism in the urine and confirmed by inoculation of laboratory animals, but in many cases the disease escapes early recognition because tuberculous infection is not suspected. Hence any symptom, sign or laboratory finding that may lead one to suspect the diagnosis of renal tuberculosis is worthy of investigation.

### Calcified Mesenteric Lymph Nodes

Calcified mesenteric lymph nodes are seen frequently in the routine roentgenograms of the urinary tract. They attract attention only in the rare cases when it is necessary for them to be distinguished from urinary calculi. Although several conditions are believed to be responsible for the pathologic change in the lymph nodes that is followed by calcification, the vast majority of calcified mesenteric lymph nodes have been the seat of tuberculous infection. This fact prompted the study of the incidence of calcified mesenteric lymph nodes in cases of proved renal tuberculosis. To accomplish this, the intravenous urograms and retrograde pyelograms in 145 consecutive cases of renal tuberculosis were examined. In each of these, nephrectomy had been performed so a pathological as well as bacteriologic diagnosis had been made. This series was compared with a series of 145 consecutive cases of surgically treated renal lithiasis in which the diagnosis of renal tuberculosis was excluded.

Calcified mesenteric lymph nodes were found to be present in 13 per cent of the roentgenograms of patients suffering from proved renal tuberculosis. This incidence was more than twice that found in a comparable series of patients not suffering from renal tuberculosis.

### Tuberculous Epididymitis

Although it is generally known that renal tuberculosis is fairly frequently accompanied by genital tuberculosis, too often intractable epididymitis is treated for long periods before the kidneys are investigated.

In 34 (42 per cent) of the 81 male cases of proved renal tuberculosis incorporated in the preceding study, genital tuberculosis also was present. None of the 93 male subjects in the group with nontuberculous kidneys suffered from inflammation of the genitalia. Thirty-one of the 34 patients had proved tuberculous epididymitis, and the remaining three were believed to have tuberculous prostatitis. In 15 of these cases it was necessary to remove the kidney on the same side as the involved epididymis, and in seven cases the kidney on the opposite side from the involved epididymis was removed. In nine cases both epididymides were involved.

The frequency of concomitant genital and renal tuberculosis is so great that the genitalia of every male patient complaining of urinary symptoms should be carefully examined for evidence of tuberculosis. Although renal tuberculosis frequently occurs in the absence of genital tuberculosis, the latter is accompanied more often than not by renal

tuberculosis. Every male patient who has epididymitis of possible tuberculous nature should therefore receive complete urologic investigation, even in the absence of urinary symptoms. Only in this manner will the early renal lesions of tuberculosis be detected.

## Pulmonary Tuberculosis

Since it seems to be the general opinion that renal tuberculosis largely, if not entirely, represents a secondary hematogenous focus of tuberculous activity resulting from a primary pulmonary infection, it was decided to investigate the incidence of pulmonary involvement in these 290 cases. To do this the pulmonary roentgenograms of the 145 proved renal tuberculosis patients and the 145 control patients suffering from operative renal lithiasis were reviewed. As shown in the table, each case was relegated to one of three categories: first, the healed or active adult type of tuberculosis; second, the healed childhood type of tuberculous infection, which often is referred to as the Ghon complex; and finally those not showing any pulmonary pathologic change whatsoever, which were designated as negative.

INCIDENCE OF PULMONARY TUBERCULOSIS IN CASES OF RENAL TUBERCULOSIS AND OF NONTUBERCULOUS RENAL LITHIASIS

| Thoracic involvement | Patients with renal tuberculosis | | Patients with nontuberculous kidneys | |
|---|---|---|---|---|
| | No. of Cases | Per cent distribution | No. of Cases | Per cent distribution |
| All types | 145 | 100 | 145 | 100 |
| Healed or active adult type | 50 | 34 | 6 | 4 |
| Healed childhood type (Ghon complex) | 20 | 14 | 20 | 14 |
| None | 75 | 52 | 119 | 82 |

The findings clearly indicate the frequency in our series with which renal tuberculosis is associated with demonstrable healed or active adult type pulmonary tuberculosis. The frequency of the healed childhood type of tuberculosis was the same in the two series.

## Summary and Conclusions

The diagnosis of renal tuberculosis can be established with relative ease once this disease is suspected. Too frequently this condition, whose successful treatment depends on its early diagnosis, is not considered. The incidences of three easily demonstrable tuberculous lesions often associated with renal tuberculosis have been determined. The presence of any of these associated conditions should cause one to suspect renal tuberculosis.

The presence of calcified mesenteric lymph nodes in the roentgenograms of a patient suffering from a urologic disease should cause one to consider the diagnosis of renal tuberculosis since they are more than twice as frequent in cases of renal tuberculosis as in nontuberculous patients.

Since epididymitis occurred in 38 per cent of 81 cases of renal tuberculosis but did not occur in a control group of 93 cases, every case of intractable epididymitis should be considered tuberculous until proved otherwise. The condition of the kidneys of such a patient should be promptly evaluated.

Since roentgenographic evidence of healed or active adult type of pulmonary tuberculosis is more than eight times as frequent in cases of renal tuberculosis as in a comparable control group, in every case of renal tuberculosis the patient should have the benefit of a stereoroentgenogram of the thorax. Renal tuberculosis should be excluded in any case of pulmonary tuberculosis with subjective or objective urinary findings.

*Extrarenal Tuberculous Lesions Associated with Renal Tuberculosis, David S. Cristol, M.D., and Laurence F. Greene, M.D., The New England Journal of Medicine, September 21, 1944.*

SUPPLIED BY

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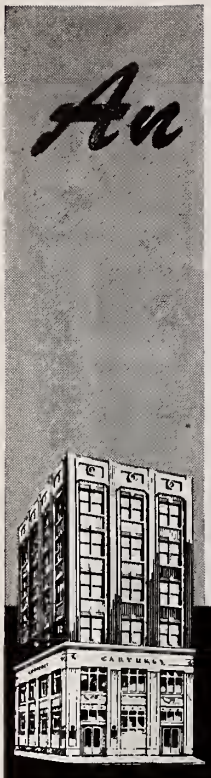
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*Silverman, D. N.; Amer. J. Digest. Dis. & Nut., 4:281-282 (July) 1937.

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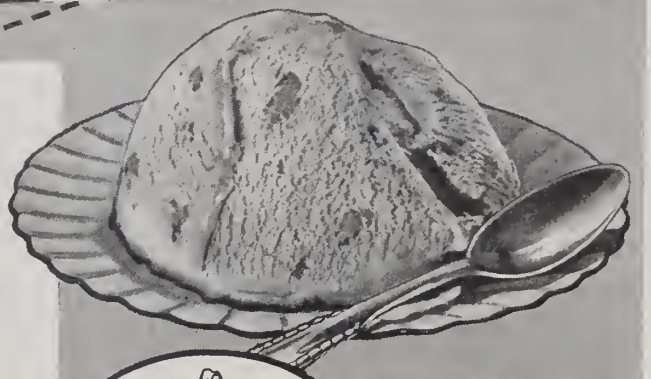
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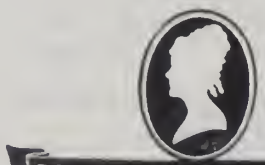
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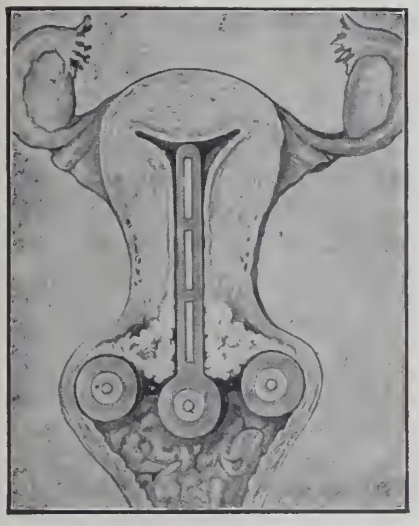
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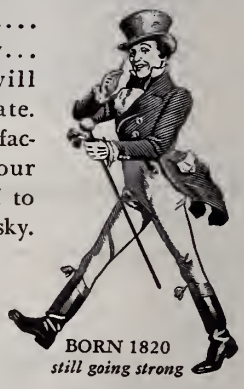


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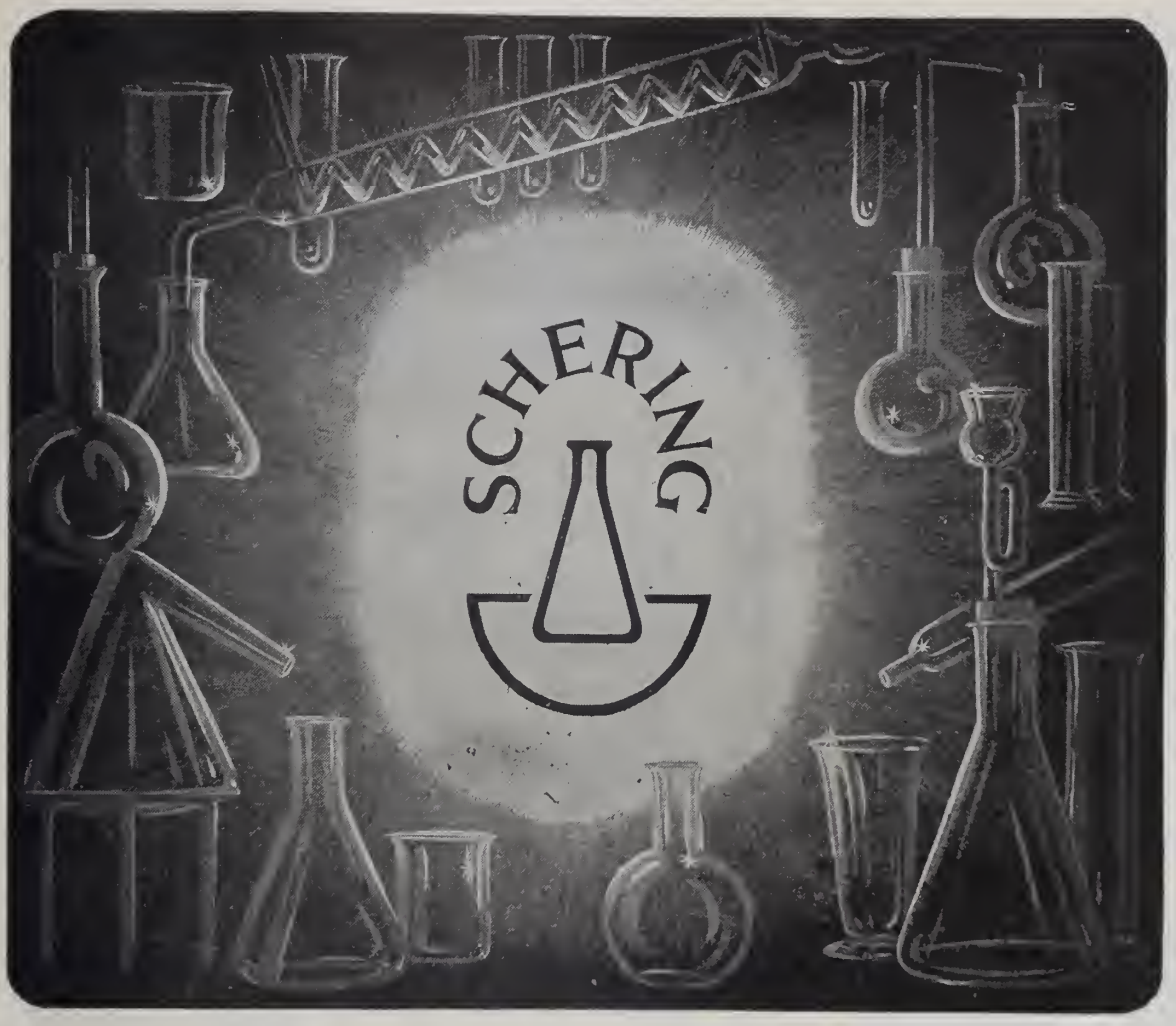
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BURROUGHS WELLCOME & CO. (U.S.A.) INC. 9-11 E. 41st St., New York 17, N. Y.




# THE FLASK AND CRUCIBLE

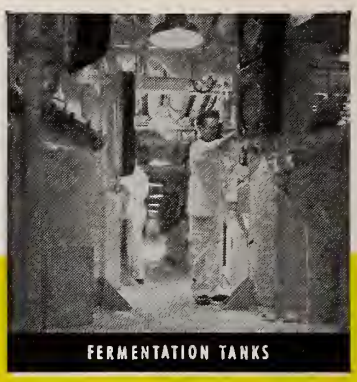
The flask and crucible of the Schering trade-mark are far from empty symbols . . . they represent an acknowledgment of our debt to the science of chemistry for the therapeutic agents which bear the Schering label. And they represent a dedication of Schering's ever-expanding research facilities to the task of probing further and further into the secrets of chemotherapy . . . secrets which hold the promise of so much for so many.

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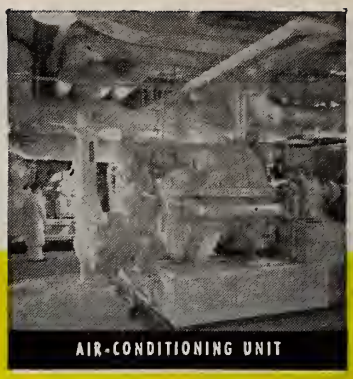
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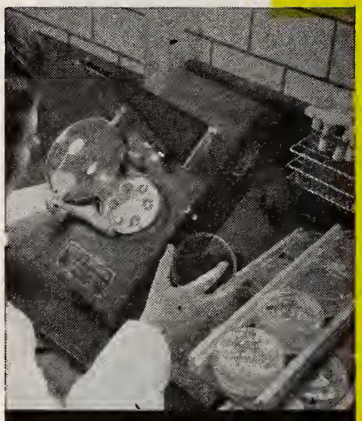
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FERMENTATION TANKS



AIR-CONDITIONING UNIT



MEASURING INHIBITION ZONES

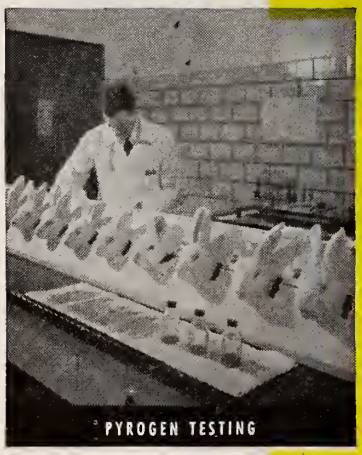
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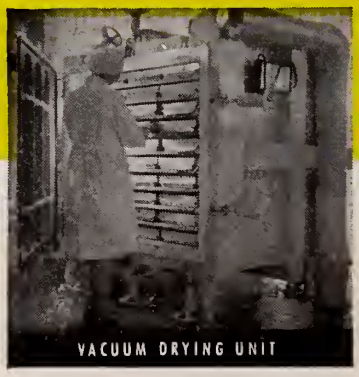
# PENICILLIN



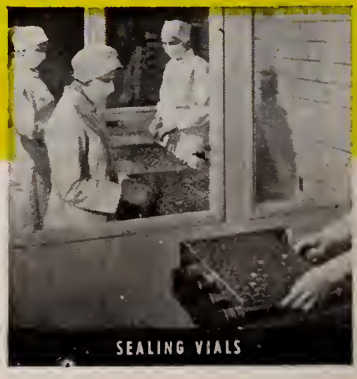
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# NEW $3,000,000 "DEEP TANK" LABORATORIES— SCIENTIFIC STAFF WITH SPECIALIZED KNOW-HOW— MAKE CHEPLIN A LEADER AMONG PENICILLIN PRODUCERS

WORLD WAR II—and the critical need for life-saving penicillin—has changed Cheplin Laboratories from a modest manufacturer, specializing for two decades in parenteral therapeutics, to one of the five largest producers of penicillin in the world. This almost miraculous metamorphosis is not the result of haphazard growth. It is the result of careful planning by far-seeing, aggressive management and a carefully-selected, balanced staff of technicians and scientists.

MANUFACTURING LABORATORIES — Cheplin's new, air-conditioned penicillin laboratories represent an investment of $3,000,000. Our facilities are devoted solely to the manufacture of penicillin by the "deep tank method" which gives high yield at low cost.

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*Now in use on the battle fronts, for speedy evacuation of wounded from nearly inaccessible areas, is this Helicopter with "capsule" stretchers attached to sides*




WHEREVER our soldiers are fighting, Army medical men have established a speedy life line for wounded. So fast and so efficient is it that often the wounded are under the care of skilled medical officers *within a matter of mere minutes!*

In this stepped-up tempo of war, however, the Army doctor finds little "time out" for himself. When there is a "break" in his long hours, his relaxation may be limited to a few pleasant moments with a cigarette . . . very likely a Camel, for Camels are such a big favorite with men in all the services.

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This lumbosacral support is specifically designed to limit the range of the lumbar spine bending when either the framework or soft tissues of the low back are the seat of injury or disease. Effective support is given the gluteal region, the lumbar spine and the sacro-iliac and lumbo-sacral joints. The adjustment about the pelvic girdle prevents undue pressure of the upper adjustments and yet the presence of the center adjustment gives relief and comfort to the patient. Provision is made for reinforcement with aluminum uprights when indicated.

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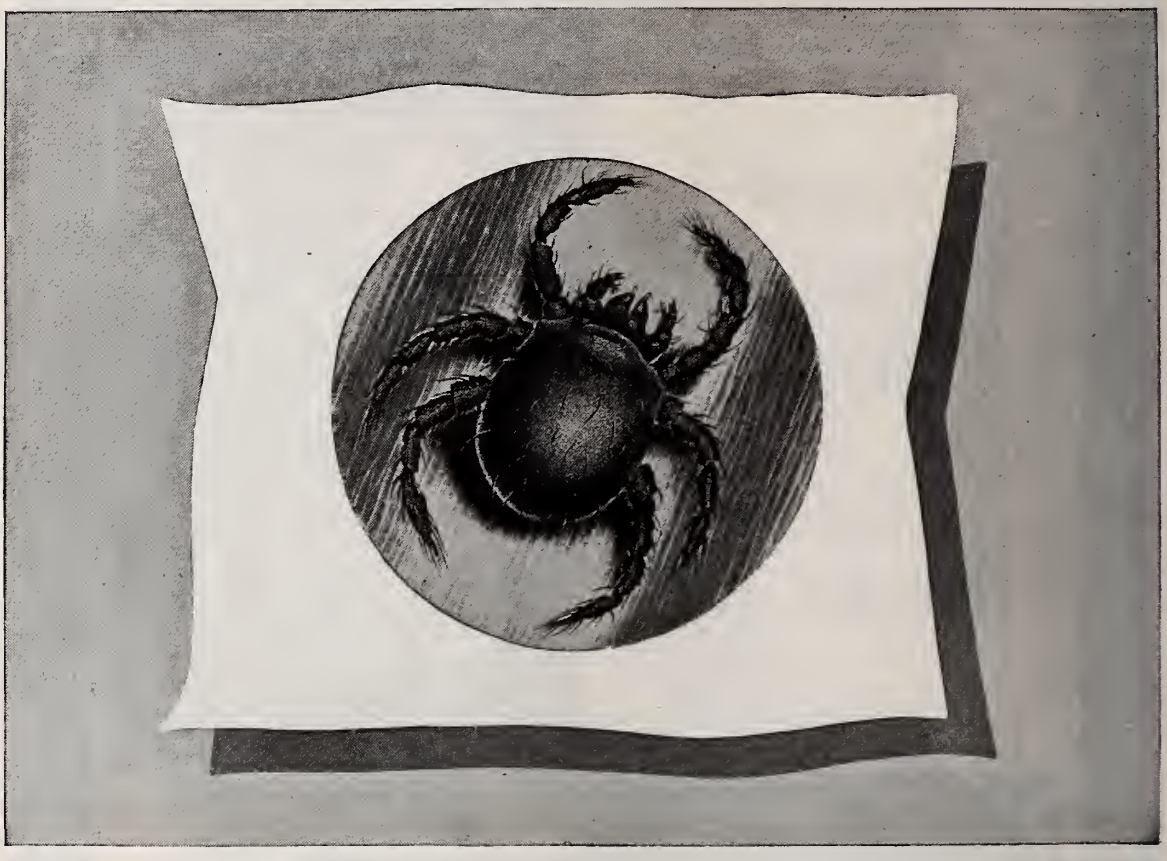
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# Effective Prophylaxis, Efficient Treatment for *CHIGGERS!*

(RED BUGS)




NOW'S THE TIME THE TROUBLESOME CHIGGER MITE starts his regular summer offensive!

But he folds up quickly, completely—under the effective action of Sulfur Foam Applicators, Wyeth.

These applicators distribute particles of sulfur evenly, thoroughly, over the body in a most effective medium —bland soap foam.

N. B.: "The superiority of this form of sulfur over powders, ointment, pastes, etc., is without challenge!"*

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*Romeo, Z. J.: Sulfur and Soap as Effective Prophylaxis Against "Chiggers" (Red Bugs) in the Army, Mil. Surgeon, *90*:437-439 (April) 1942.

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*to Every Member of the Medical Profession*





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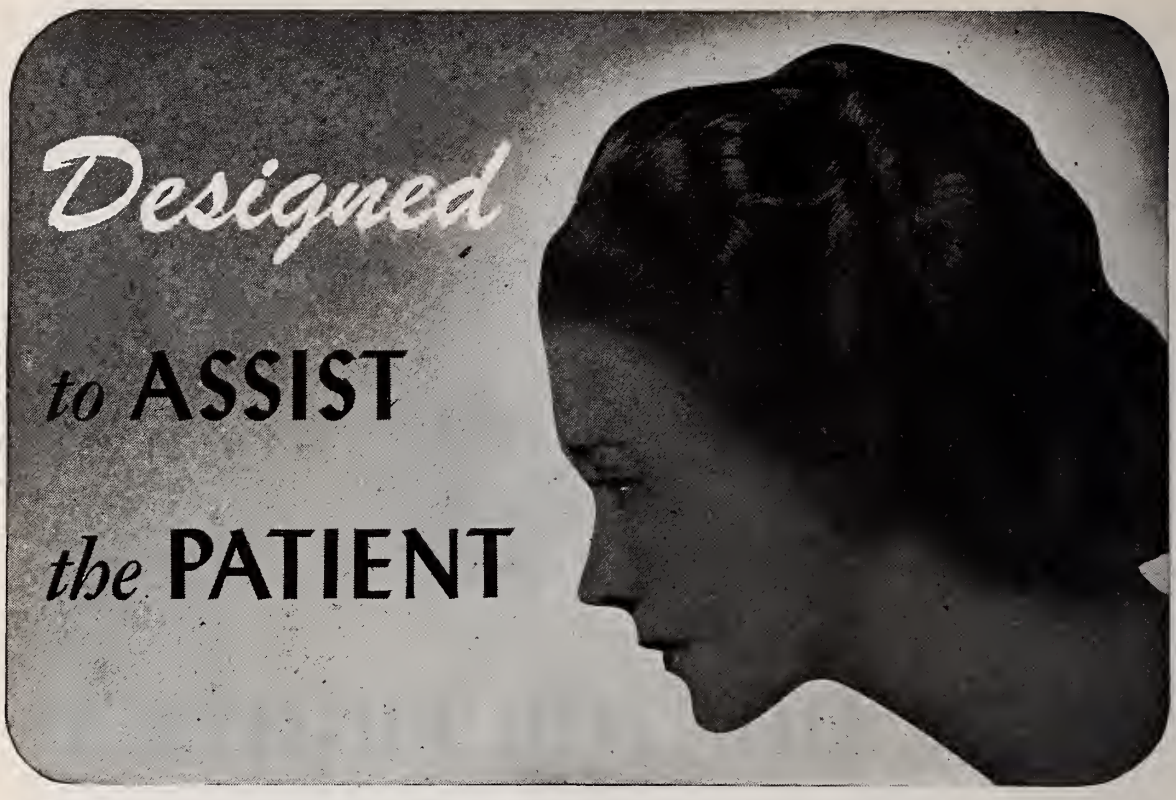
*Now on the Air Every Tuesday with a Distinguished Cast*

AGAIN you will hear, brilliantly dramatized, recent outstanding achievements of physicians both overseas and on the homefront. The message brought by "THE DOCTOR FIGHTS" will make it a program of exceptional interest to you.

*Tuesday Evenings:* COLUMBIA BROADCASTING SYSTEM
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THE "RAMSES"* Diaphragm Introducer, designed after consultation with gynecologists, engages the rim of the "RAMSES" Flexible Cushioned Diaphragm at two points, shaping it into an elongated oval, thus enabling it to pass readily into the vagina. By providing complete control over the direction of travel, the "RAMSES" Diaphragm Introducer assures proper and accurate placement of the diaphragm.

**1.** The wide, blunt tip of the "RAMSES" Diaphragm Introducer is designed to prevent even the remote chance of accidental penetration of the uterus during insertion of the diaphragm.

**2.** Made of easily cleansed plastic, the "RAMSES" Diaphragm Introducer has no minute crevices to harbour bacterial growth—no sharp projections to cause possible vaginal injury.

**3.** The broad, rounded hooked end of the "RAMSES" Diaphragm Introducer—used for diaphragm removal—guards against possible entry into the urethra.

***Your patients obtain the "RAMSES" Diaphragm Introducer when you specify the "RAMSES" Physicians Prescription Packet No. 501.***

**"RAMSES" Gynecological Products are suggested for use under the guidance of a physician only. They are available through recognized pharmacies.**

**The word "RAMSES" is the registered trademark of Julius Schmid, Inc.*

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Gynecological Division
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*Established* 1883.
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**DIAPHRAGM INTRODUCER**



*Indicated therapy in Sequelae of*

*Epidemic Encephalitis*

# Pills Stramonium (*Davies, Rose*)

**2½ grains**

Physicians in private practice as well as in neurological clinics have widely prescribed these pills since 1929, and their continued interest in and use of them point to the serviceability of this therapy.

Stramonium Pills (*Davies, Rose*) exhibit in each pill 2½ grains of alkaloidally standardized Stramonium (powdered dried leaf and flowering top of Datura Stramonium, U.S.P.), equivalent to 25 minims (1.54 cc.) of Tincture U.S.P.

As a reassurance of the activity of the finished pills, they, too, are alkaloidally assayed, thus establishing as far as possible uniformity and dependability.

*A package for clinical trial and literature mailed free of charge upon request.*



**Davies, Rose & Company, Limited**

Manufacturing Chemists, Boston 18, Massachusetts

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## HANGER ARTIFICIAL LIMBS RESTORE MEN TO LIVES OF ACTIVITY AND USEFULNESS



**Among those in the Armed Forces to whom Hanger Limbs have been supplied in recent months are:**

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. . . a Lt. Comdr. in the Royal Navy
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. . . Seamen-First Class, U. S. Navy
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**PERFECT FIT — COMFORT and PERFORMANCE**

The result of over 80 years research,
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**New York 11, N. Y.**

**334 NO. 13th ST.**
**Philadelphia 7, Pa.**

**and other cities**

# *Penicillin* DOSAGE TABLE*

| INDICATIONS | INITIAL DOSE (UNITS) | CONTINUING DOSAGE (UNITS) | UNITS IN 24 HR. | REMARKS |
|---|---|---|---|---|
| ***Serious Infections*** (staphylococcus, clostridium, hemolytic streptococcus, anaerobic streptococcus, pneumococcus, gonococcus, anthrax, meningococcus)<br>Adults and children | 15,000 to 20,000 | (a) Intravenous drip: 2000 to 5000 every hr. | 40,000 to 120,000 or more | (a) Dissolve ½ of 24 hr. dose in 1 liter (1000 cc.) normal saline; let drip at 30 to 40 drops per minute. |
| | | or<br>(b) Intramuscularly: 10,000 to 20,000 every 3 or 4 hr. | 40,000 to 120,000 or more | (b) Concentration: 5000 U. per cc. normal saline. |
| | | or<br>(c) Intramuscular drip | 40,000 to 120,000 or more | (c) Total daily dose in 250 cc. normal saline. |
| Infants | 5000 to 10,000 | 3000 to 10,000 intramuscularly every 3 hr. | 20,000 to 40,000 or more | Each dose in 1 or 2 cc. of normal saline. |
| ***Chronically infected*** compound injuries, osteomyelitis, etc.<br>Adults and children | 5000 to 10,000 | 10,000 every 2 hr. or 20,000 every 4 hr. intramuscularly or intravenously. Larger doses may be necessary at times. | 40,000 to 120,000 or more | Concentration for intramuscular inj.: 5000 U. per cc. normal saline.<br>For intravenous inj.: 1000 to 5000 U. per cc.<br>Supplement with local treatment. |
| ***Gonorrhea*** | 20,000 every 3 hr. intramuscularly for 5 doses | | 100,000 | Results of treatment should be controlled by culture of exudate. |
| ***Empyema***<br>Adults and children | 30,000 to 40,000 once or twice daily into empyema cavity | | 30,000 to 80,000 | Dissolve in 20 to 40 cc. normal saline and inject into empyema cavity after aspiration of pus. |
| ***Meningitis***<br>Adults and children | 10,000 once or twice daily into subarachnoid space or intracisternally | | 10,000 to 20,000 | Concentration: 1000 U. per cc. normal saline. |
| ***Bacterial Endocarditis***<br>Adults and children | 25,000 to 40,000 | 25,000 to 40,000 every 3 hr. intramuscularly | 200,000 to 300,000 | Continuous treatment for 3 weeks or longer. In a few cases the intravenous drip is more advantageous. |

*Based upon recommendations by Chester S. Keefer, *War Production Board Penicillin Leaflet*, Apr. 1, 1945; and by Wallace E. Herrell and Roger L. J. Kennedy, *Journal of Pediatrics*, 25:505, Dec., 1944.

*Write for pocket size copies of this Dosage Table*

ACCEPTED AMERICAN MEDICAL ASSN. Council on Pharmacy and Chemistry

**Penicillin Sodium–Winthrop is available in vials (with rubber diaphragm stopper) of 100,000 Oxford Units.**

WINTHROP CHEMICAL COMPANY, INC.

*Pharmaceuticals of merit for the physician*

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# WALKER-GORDON OFFERS

## an almost sterile milk ...Certified-Pasteurized!

As you probably know, Walker-Gordon Certified is generally accepted as the world's finest milk.

And now—*at no extra cost*—your patients can buy Walker-Gordon Certified-*Pasteurized* . . . a milk that is practically sterile!

In these days when every-other-day milk delivery is being put into effect in many cities, the keeping quality of milk is vitally important.

That's why the Boston Health Department made the following test, which proved that the purity of Certified-Pasteurized is little short of miraculous:

**GROWTH OF COLONIES OF BACTERIA FROM A CUBIC CENTIMETER OF MILK**

| TYPE OF MILK | NO. OF SAMPLES | | NO. OF COLONIES | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | ON DELIVERY | 1 DAY AT 40°F. | 2 DAYS AT 40°F. | 3 DAYS AT 40°F. | 4 DAYS AT 40°F. | 5 DAYS AT 40°F. |
| Certified-Pasteurized | 22 | Maximum | 20 | 40 | 100 | 850 | 1000 | 1400 |
| | | Minimum | 0 | 4 | 5 | 8 | 15 | 20 |
| | | Average | 8 | 14 | 44 | 157 | 286 | 770 |

• In discussing this table, the chemists stated that *even after ninety-six hours in the refrigerator*, Certified-Pasteurized still "conformed to the bacterial standards and was perfectly safe for use as measured by present knowledge of the subject."

The report . . . the complete results of which appeared in the *New England Journal of Medicine* . . . was made by the Laboratory for Chemistry and Sanitary Biology, Boston Health Department. If you'd like to have a reprint of the entire study, write to Walker-Gordon, Inc., Plainsboro, N. J.

There simply isn't any purer, more healthful, or better-tasting milk!

## POWERFUL TO DECONGEST



***Powerless to Re-congest***... In the symptomatic treatment of common colds and sinusitis, Neo-Synephrine is noteworthy for its long-lasting decongestive action which promotes breathing comfort and facilitates sinus drainage. Noteworthy also is its marked freedom from compensatory re-congestion and systemic side effects.

# Neo-Synephrine

## HYDROCHLORIDE

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**FOR NASAL DECONGESTION**




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**THERAPEUTIC APPRAISAL:** Quick-acting, long-lasting...nasal decongestion without compensatory re-congestion or significant stimulation of the heart and central nervous system; consistently effective upon repeated use; no appreciable interference with ciliary activity; isotonic to avoid irritation.

**INDICATED** for symptomatic relief in common cold, sinusitis, and nasal manifestations of allergy.

**SUPPLIED** in ¼% and 1% solutions, bottles of 1 fl. oz.; ½% jelly in collapsible tube with applicator.

**ADMINISTRATION** may be by dropper, spray, or tampon, using the ¼% solution in most cases and the 1% when a stronger solution is indicated. The ½% jelly in tubes is convenient for patients to carry.

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# "don't smoke"...

*IS ADVICE HARD FOR PATIENTS TO SWALLOW!*

May we suggest, instead, *SMOKE "PHILIP MORRIS"?* Tests* showed 3 out of every 4 cases of smokers' cough cleared on changing to PHILIP MORRIS. Why not observe the results for yourself?

**Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154*

TO THE PHYSICIAN WHO SMOKES A PIPE: We suggest an unusually fine new blend—COUNTRY DOCTOR PIPE MIXTURE. Made by the same process as used in the manufacture of Philip Morris Cigarettes.

# S·I·M·I·L·A·C

*Similar to human milk*




**★The name is never abbreviated; and the product is not like any other infant food—notwithstanding a confusing similarity of names.**

The fat of Similac has a physical and chemical composition that permits a fat retention comparable to that of breast milk fat (Holt, Tidwell & Kirk, Acta Pediatrica, Vol. XVI, 1933) . . . In Similac the proteins are rendered soluble to a point approximating the soluble proteins in human milk . . . Similac, like breast milk, has a consistently ZERO curd tension . . . The salt balance of Similac is strikingly like that of human milk (C. W. Martin, M. D., New York State Journal of Medicine, Sept. 1, 1932). *No other substitute resembles breast milk in all of these respects.*

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A powdered, modified milk product especially prepared for infant feeding, made from tuberculin tested cow's milk (casein modified) from which part of the butter fat is removed and to which has been added lactose, olive oil, cocoanut oil, corn oil and fish liver oil concentrate.

**SIMILAC } SIMILAR TO HUMAN MILK**

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# How Long is a good night's sleep?

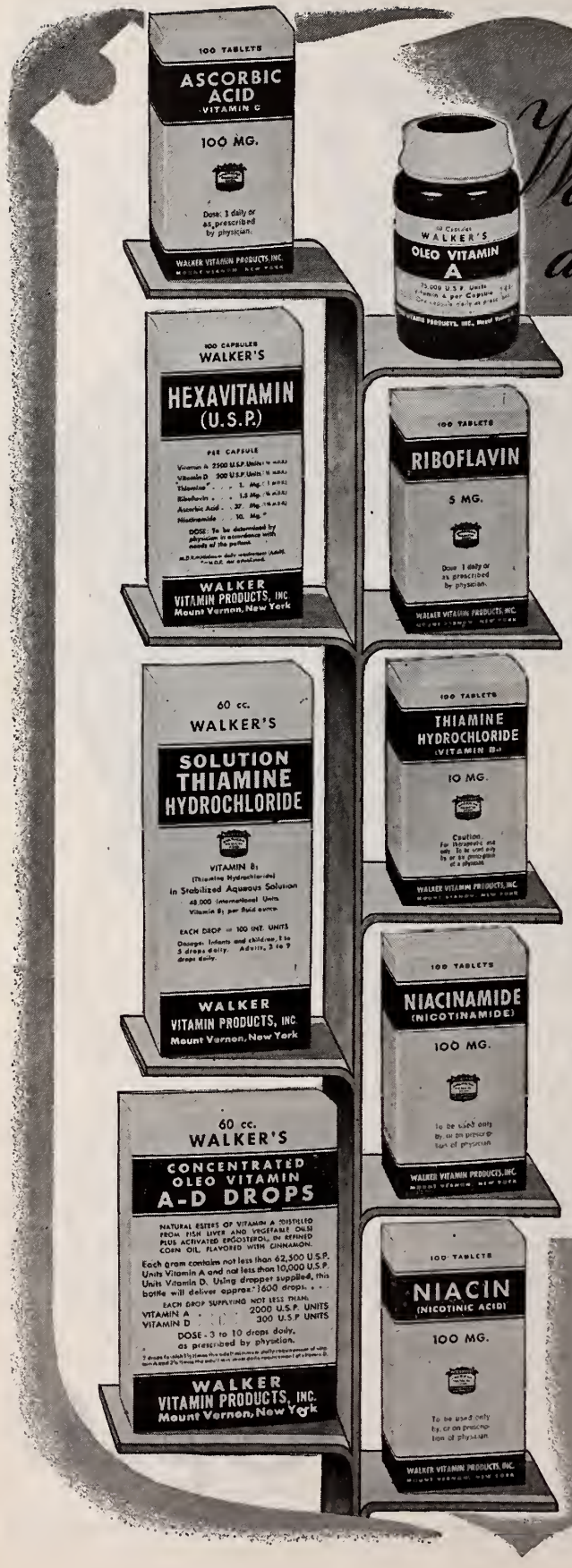


*Four? Eight? Sixteen hours?* Eight hours most closely approximate the requirements for normal physiological recuperation. Ipral functions within this range. Given one hour before retiring, Ipral will carry the patient through a full night's sleep, unlike the shorter-acting hypnotics whose effects wear off quickly. Ipral will then permit the patient to wake up in the morning generally calm and refreshed; free from the lassitude of longer-acting hypnotics. Ipral Calcium (calcium ethylisopropyl barbiturate Squibb) in 2-grain unidentifiable tablets.

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(25 Mg., 50 Mg., 100 Mg.)

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(25 Mg., 50 Mg., 100 Mg.)

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(25 Mg., 50 Mg., 100 Mg.)

**SOLUTIONS**

**Solution Thiamine Hydrochloride (Oral)**
(100 I.U. per drop)

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The physician planning a diabetic's diet with 'Wellcome' Globin Insulin will find it convenient to divide his patient's carbohydrate intake into tenths. Two-tenths for breakfast, three-tenths for lunch, one-tenth for a mid-afternoon snack, and four-tenths for supper will be found satisfactory for most patients.

Such a regime plus one injection of Globin Insulin daily will control most mild, moderate, and many severe cases of diabetes. Action is rapid in onset, sustained during daytime activity, and diminished at night—thus minimizing the likelihood of nocturnal reactions.

'Wellcome' Globin Insulin with Zinc is a clear solution and, in its relative freedom from allergenic properties, is comparable to regular insulin. Council accepted. Developed in the Wellcome Research Laboratories, Tuckahoe, New York. U. S. Patent No. 2,161,198. Available in vials of 10 cc., 80 units in 1 cc. 'Wellcome' Trademark Registered



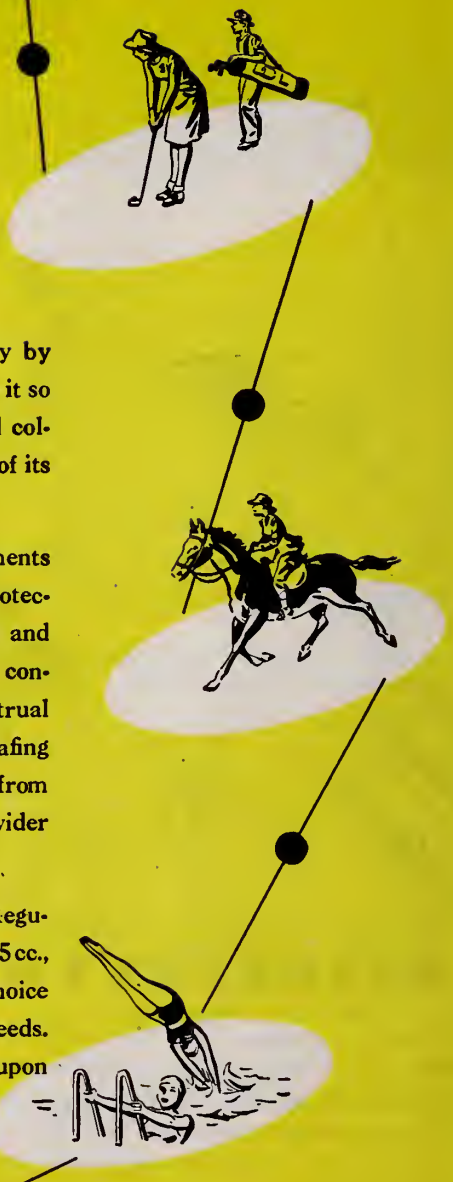

*Literature on Request*

BURROUGHS WELLCOME & CO. (U. S. A.) INC., 9 & 11 East 41st Street, New York 17, N.Y.

# Does Tampax "Flat Expansion" assure "Natural Comfort"?

## DECIDEDLY—

## Yes



Only "flat expansion", provided exclusively by TAMPAX, can assure "natural" comfort. Because it so closely conforms to the contour of the normal collapsed vagina, many women are hardly aware of its presence in situ.[1]

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# TAMPAX

ACCEPTED FOR ADVERTISING BY THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION

REFERENCES: 1. West. J. Surg. & Gyn., 51:150, April, 1943. 2. Clin. Med. & Surg., 46:327, August, 1939. 3. Am. J. Obst. & Gynec., 46:259, 1943.

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Statistical studies reveal that approximately thirty per cent of syphilitic patients exhibit abnormalities in the spinal fluid during initial examinations, without displaying clinical symptoms of cerebrospinal involvement. Although adequate routine treatment of early syphilis will prevent the appearance of abnormalities in most cases, the use of Tryparsamide Merck combined with hyperthermy, is suggested in resistant cases.

In incipient cases of dementia paralytica, the use of Tryparsamide Merck, combined with artificial fever therapy, is known to produce varying degrees of symptomatic improvement. While favorable results may not be expected in more advanced cases of general paresis or tabes dorsalis, when treatment is begun sufficiently early and continued over a long period of time, Tryparsamide Merck may arrest deterioration and contribute to the prolongation of life.

The effectiveness of Tryparsamide Merck in the treatment of resistant cases of syphilis probably is due to its unusual ability to penetrate the meningovascular barrier of the central nervous system.




Semidiagrammatic

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# Hot weather presents no problem when Lactogen is used for infant feeding . . . because




. . . when refrigeration is not available, each feeding may be prepared separately. The doctor can always advise the mother to prepare individual LACTOGEN feedings whenever the baby is ready for his bottle. Preparing each LACTOGEN feeding just before feeding time safeguards the baby against the danger of nutritional upsets caused by bacteriological changes in the formula.

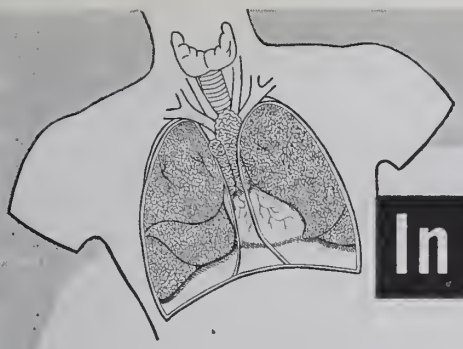
## EASY TO PRESCRIBE

| LACTOGEN | + WATER | = FORMULA |
|---|---|---|
| 1 LEVEL TABLESPOON | 2 OUNCES | 2 FLUID OUNCES |
| 40 CALORIES | | 20 CALORIES |
| (APPROX.) | | PER OZ. (APPROX.) |

No advertising or feeding directions except to physicians. For feeding directions and prescription pads, send your professional blank to

**Nestlé's Milk Products, Inc.**

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# In the Pneumonias

DURING the recent past, numerous investigations have shown that penicillin is the treatment of choice in the pneumonias (pneumococcic, streptococcic, staphylococcic).* Penicillin is virtually nontoxic, even in the massive dosages at times required. Its efficacy apparently is the same against sulfonamide-resistant and nonresistant organisms of the groups named. Even in advanced stages of the disease, in the presence of serious complications, penicillin usually proves a life-saving measure.

Since penicillin has become available in quantities that may well be adequate for all needs, it merits being the physician's first thought with every pneumonia patient.


*Stainsby, W. J.; Foss, H. L., and Drumheller, J. F.: Clinical Experiences with Penicillin, Pennsylvania M. J. 48:119 (Nov.) 1944.

McBryde, A.: Hemolytic Staphylococcus Pneumonia in Early Infancy; Response to Penicillin Therapy, Am. J. Dis. Child. 68:271 (Oct.) 1944.

Stainsby, W. J., Chairman, Commission for the Study of Pneumonia Control of the Medical Society of the State of Pennsylvania: Up-to-Date Facts on Pneumonia, Pennsylvania M. J. 48:266 (Dec.) 1944.

Larsen, N. P.: Observations with Penicillin, Hawaii M. J. 3:272 (July-Aug.) 1944.


## PENICILLIN-C.S.C.

Penicillin-C.S.C. deserves the physician's preference not only in the pneumonias, but whenever penicillin therapy is indicated. Rigid laboratory control in its manufacture, and bacteriologic and biologic assays, safeguard its potency, sterility, nontoxicity, and freedom from pyrogens. The state of purification reached in Penicillin-C.S.C. is indicated by the notably small amount of substance required to present 100,000 Oxford Units. Because of this purity, incidence of the undesirable reactions, attributed by many investigators to inadequate purification, is greatly reduced.

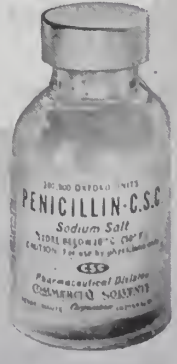
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ACCEPTED AMERICAN MEDICAL ASSN Council on Pharmacy and Chemistry

Penicillin-C.S.C. stands accepted by the Council on Pharmacy and Chemistry of the American Medical Association.






Syntropan has the desirable, antispasmodic actions of belladonna or atropine, but does not depress salivary secretion as actively nor induce mydriasis as readily. When used to induce mydriasis, its influence is not as profound nor as long in duration as that of atropine. The inhibitory action of Syntropan on the parasympathetic innervation of the heart is negligible and not as pronounced as that of atropine. Syntropan has a definite antispasmodic action on spastic smooth muscle, the antispasmodic influence being due jointly to inhibition of the parasympathetic innervation and to direct peripheral relaxing action on the muscle fibers themselves . . . HOFFMANN-LA ROCHE, INC., NUTLEY 10, NEW JERSEY

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*"When American people as a whole are educated to the fact that their...physician is the one best qualified to give authoritative information on matters pertaining to health ... then only may they properly be fortified against the inroads of disease."*

*Edit.: Ill. Med. J. 82:407 (Dec.) 1942*

To the above we subscribe wholeheartedly.

We believe it is the physician's role to diagnose the condition and prescribe the treatment.

We not only believe this—we live it, as a practical, working creed:

White Laboratories neither prepare nor send out advertising directed to the consumer.

We depend upon the physician to prescribe White's Pharmaceutical Products when they are indicated—

Just as the physician can depend upon White's for constant research, careful manufacture, standardization and complete cooperation.

PHARMACEUTICAL White MANUFACTURERS

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NEWARK 3, N. J.




# "MORE PROTEIN AND LESS FAT SHOULD BE JUST WHAT HE NEEDS, SO—"

"I want to put him on DRYCO, and we can adjust the formula to suit his requirements."

DRYCO is a scientifically adjusted powdered milk food ...ideally suited to a wide variety of high-protein, low-fat formulas (2.7 to 1 protein-fat ratio).

Also, DRYCO may be prescribed with or without added sugar for high or low carbohydrate values. It is quickly soluble in *cold* or *warm* water—and may be safely employed in concentrated form.

Because DRYCO assures adequate protein intake with minimal gastro-intestinal upsets from fat indigestion...and because of its optimum mineral and vitamin content, physicians depend on DRYCO for normal as well as "special" infant feeding cases.




BORDEN'S PRESCRIPTION PRODUCTS DIVISION
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USE **DRYCO** THE "CUSTOM FORMULA" INFANT FOOD

*DRYCO is made from spray-dried, pasteurized, superior quality whole milk and skim milk. Provides 2500 U. S. P. units vitamin A and 400 U. S. P. units vitamin D per reconstituted quart. Supplies 31½ calories per tablespoon. Available at all drug stores in 1 and 2½ lb. cans.*

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# PROCAINE HYDROCHLORIDE AND EPINEPHRINE

The combination of the prompt and powerful local anesthetic action of procaine hydrochloride with epinephrine is very effective. With CHEPLIN PROCAINE HYDROCHLORIDE and EPINEPHRINE the period of anesthesia is prolonged through retarded absorption of the anesthetic. It also causes blanching of the operative area, thus giving the surgeon a clear field.

*Literature on request*

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*1% PROCAINE HYDROCHLORIDE and 1:25,000 EPINEPHRINE* is supplied for subcutaneous and intramuscular use in ampules and vials.

**CHEPLIN LABORATORIES INC.** SYRACUSE 1, NEW YORK

# the local problem in ACNE VULGARIS

The local problem in acne vulgaris is to remove the excessive sebum with the least amount of irritation. This cannot be accomplished with ordinary soap and water as easily as with sulfated oils. Swartz and Blank report gratifying results when Acidolate, the modern sulfated-oil detergent, is utilized in place of soap to secure and maintain skin cleanliness (*J.A.M.A., 125: p. 30-31,* May 6, 1944).

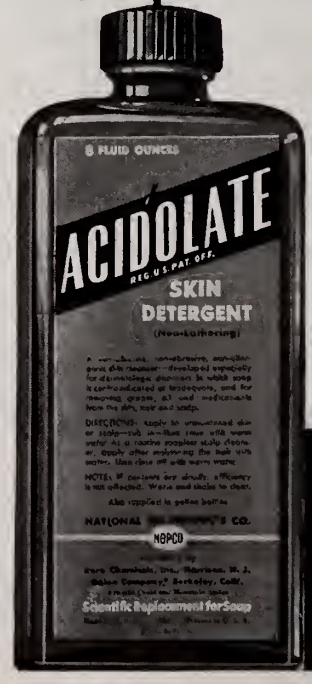
Acidolate, founded on scientific research and backed by extensive clinical experience, offers the following advantages:

1. It is a logical and competent solvent of sebum.

2. It contains only those fatty acids that are non-irritating to the skin.

3. Its pH of 6.25 is compatible with that of the skin.

4. It is non-abrasive, water-miscible, and free of perfume and pigment.




*Literature and sample to physicians on request*

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*Acidolate is a trademark of National Oil Products Co.

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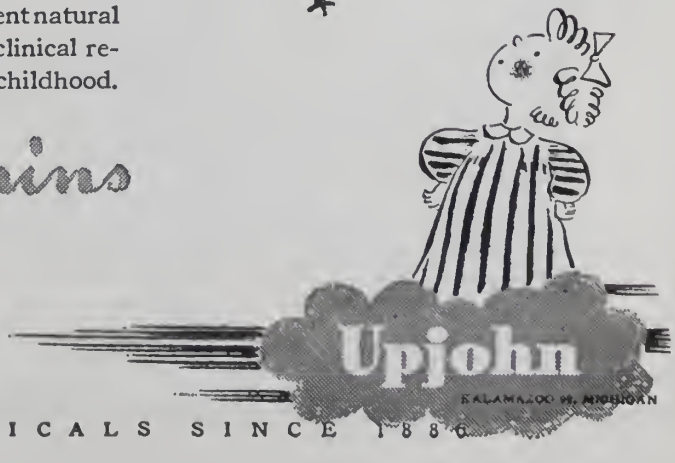
# By the light of the moon

Might as well expect the average child to get adequate vitamin D "by the light of the moon" as to depend wholly on the sun. Even in the summertime when the sun is shining many children are not as exposed to it as we might think. Cloud filtration and the uncertainty of adequate exposure even in such sunny areas as California[1] have led leading nutritionists to the conclusion that supplementation with vitamin D is essential. Essential as long as growth persists—through infancy, childhood and adolescence.

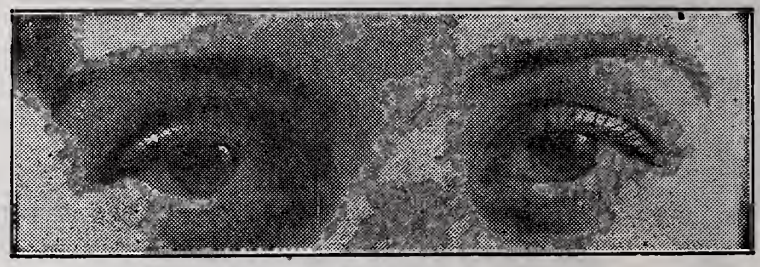
Regardless of season or geography, Upjohn makes available convenient, palatable, highly potent natural vitamin preparations to meet the varied clinical requirements of earliest infancy through late childhood.

Upjohn Vitamins

1. Am. J. Dis. Child. 54: 1227, 1937.




FINE PHARMACEUTICALS SINCE 1886



# EYES RIGHT?

***They must be . . . . these strenuous days.***

Those in the armed forces—in the factories—in civilian defense corps—and in the home must see clearly in order to do a good job.

Protect their eyesight by referring to your colleague, the Eye Physician.

His prescription, and the correct interpretation by the Guild Optician, safeguards their most precious possession.

GUILD of PRESCRIPTION OPTICIANS of AMERICA Rx

## Guild of Prescription Opticians of New Jersey, Inc.

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# Peptic Ulcer Prophylaxis

## . . . "ONE OF THE MOST IMPORTANT PHASES OF ULCER MANAGEMENT"[1]

THE LITERATURE[1-4] stresses the high incidence of recurrence in peptic ulcer and the need of constant vigil against flare-up. A return to the ulcer regimen—special diet, rest, antacids, etc.—is said to be particularly advisable during spring and autumn[4] and following emotional storms.[5]

Phosphaljel*, with its antacid, astringent and demulcent properties, provides an appropriate adjunct to such peptic ulcer prophylaxis. The value of a good buffering agent "is almost self-evident"[6] for this purpose, as well as for more resistant conditions, such as gastrojejunal ulcer, which have also been found to respond to Phosphaljel therapy[7].

*Reg. U. S. Pat. Off.

# PHOSPHALJEL

ALUMINUM PHOSPHATE GEL

Wyeth




*Supplied in 12-fluidounce bottles*

1. Backus, H. L.; Gastro-Enterology 1:471, 1943, W. B. Saunders Co., Phila. 2. Hurst, A.: Practitioner 152:193, 1944. 3. Berk, J. E.: J. Med. Soc. N. J. 41:365-370, 1944. 4. Rehfuss, M. E.: Indigestion, Its Diagnosis and Management, Phila. W. B. Saunders Co., 1943, pp. 241-243., 5. Alvarez, W. C.: Gastroenterology, 2:65-67, 1944. 6. Selye, H. and MacLean A.: Amer. J. Dig. Dis. 11:319-322, 1944. 7. Fauley, G. B., et al.: Arch. Int. Med. 67:563-578, 1941.

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*For the diabetic, Knowledge is Life*

OPTIMAL SUCCESS in the management of diabetes mellitus depends largely on the patient's knowledge of the disease. Physicians carefully educate their diabetic patients. Facts concerning blood and urine sugar, diet, exercise, Insulin, and Protamine Zinc Insulin are valuable steppingstones to successful treatment. Other things being equal, the well-trained patients live the longest.

Iletin (Insulin, Lilly) preparations are products of purity, stability, potency, and uniformity. They are subjects of constant research and are in ever-increasing demand. Eli Lilly and Company, Indianapolis 6, Indiana, U. S. A.

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Volume 42
Number 6



# THE JOURNAL
OF
# THE MEDICAL SOCIETY OF NEW JERSEY

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**Each member of the State Society is entitled to receive a copy of The Journal every month.**

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Single Copies, 30 Cents

## EDITORIALS

### SAMUEL ALEXANDER, M.D.
**Our 1945-1946 President**



Dr. Samuel Alexander was born in New York City on February 22, 1888. He attended grammar and high schools in Brooklyn, and in 1910 was graduated from Long Island Medical College. After interning in Hackensack Hospital he began to practice medicine in Park Ridge, covering northern Bergen County and southern Rockland County, New York.

Dr. Alexander's enthusiastic interest in Organized Medicine led to his election as President of the Bergen County Medical Society in 1933. He has served as a member of the Welfare Committee since 1933, and as a member of the Board of Trustees since 1938. For four years during the drafting, introduction and passage of the Uniform Medical Practice Act, Dr. Alexander served as Chairman of the Uniform Medical Practice Committee.

In addition to his local, state and national medical affiliations, our President is a member of the Medical Board of Bergen Pines Hospital, Medical Director of Meyers Sanitarium for Chronics, Park Ridge; Courtesy Staff member of Hackensack Hospital, President of Park Ridge Board of Health and President of Bergen County Health and Sanitary Association.

## MESSAGE FROM THE PRESIDENT

When the history of World War II is finally written, no branch of the service will stand out in all its ramifications more than the Medical Corps.

The physicians of New Jersey can be justly proud of the part played by the members of the Medical Society. With a total membership of 4328, 1470—or 30 per cent—have entered the Armed Forces of the United States.

Let it be clearly understood that in every instance these men volunteered for the service. They were willing to make every sacrifice necessary to make possible the winning of the war. Their training ranged anywhere from the young doctor who had just finished interning to the specialist with years of training and experience. Many of these specialized doctors were stymied when it came to promotion because most of the tables of organization were filled in grade when affiliated medical units were being organized.

The record made by the physicians of the Medical Corps is known to every man and woman in the armed forces. Never in the history of warfare has a comparable record been made.

Now that the European Theater of Operation has been victoriously concluded, we hope the war in the Pacific area will not continue many more months. Those of us who remained at home to take care of civilian needs must give serious thought to the physician returning to civilian life after his military career has ended.

In conclusion, first, we must see that returning men from the armed forces receive appointments at least equal to the ones that they had before entering the service; second, we must see that every opportunity and encouragement to practice medicine be given to them; and third, we must see that the type of medicine as they knew it will not be changed upon their return.

We cannot do less.

SAMUEL ALEXANDER, M.D.,
*President.*

---

## NAVY NEEDS DOCTORS

Every man, between the ages of 18 and 45 years of age, is subject to the provisions of the Selective Service Law. Physicians are not exempt from these provisions, excepting physicians who are accepted by the military forces in the capacity of physicians are eligible for commission in the armed forces rather than induction on an enlisted status.

The procurement of physicians to act in the capacity of physicians in our armed forces is on a voluntary basis but this voluntary effort can in no way allow for evasion of the civil obligations of a citizen physician, under the regulations of the Selective Service Law.

Selective Service, on a State and National basis, has shown extraordinary consideration to the medical profession but now requires that every physician be accounted for to determine whether or not he is filling the proper place in the war effort. To accomplish this the following letter has been mailed to every physician still in civilian practice in New Jersey who is considered available for military service by New Jersey Procurement and Assignment Service.

Dear Doctor:

The Navy is in urgent need of medical officers and in order to meet this demand the physical requirements for appointment have been appreciably lowered so that many physicians previously physically disqualified for commissions in the Army or Navy may now be appointed.

A new Selective Service Regulation (Amend-

ment of Local Board Memorandum 115) requires that all physicians who have not passed their thirty-fourth birthday must have a request for Selective Service deferment filed by the Procurement and Assignment Service. Such requests for deferment of physicians who have been previously disqualified for appointment as medical officers and who are still considered to be available for military service will not be filed with Local Selective Service Boards until the physician registrant has been found physically disqualified for appointment as a medical officer in the Navy under the present physical standards. Physicians who are found physically qualified will be expected to accept appointments as medical officers in the Navy or be subject to induction in the Selective Service. Requests for the extension of Selective Service deferment will be made for those who are not accepted by the Navy.

In order to carry out the provisions of this Directive, it will be necessary for you to have a physical examination at the Office of Naval Officer Procurement for the Third Naval District, 33 Pine Street, New York, before April 1, and you are urged to communicate with the officer in charge in that office, Commander J. J. Hayes, MC-USNR, at once. The telephone is Whitehall 3-4060. Your name has already been filed with that office.

Sincerely yours,
NORMAN M. SCOTT, M.D., Secretary,
Committee on Procurement and Assignment.

## EVOLUTION OF MEDICAL CARE PLANS IN NEW JERSEY

In 1938 special committees of The Medical Society of New Jersey began their studies to evolve a program whereby adequate medical care of high standards would be made available to all persons in New Jersey at a cost within their ability to pay.

Since that time there has developed a very definite demand from a large percentage of American people for a broadened social security program to include medical care of the individual to be paid for by compulsory taxation of wages and the profits of industry. Such a compulsory program would in our opinion lead to regimentation and control of the profession, labor and industry, a type of medical care not in accord with the best methods of medical practice, which would certainly result in a lowered standard of medical care and health of our people. An alternative is a program which will meet the needs of our people at a local level, built upon the framework of medical practice which has produced the high standards of American medicine, and which will at the same time prevent regimentation and control of the profession, labor and industry, and promote personal initiative and private enterprise.

It was soon obvious to our committees that we had three general socio-economic groups to deal with: (1) a high income group comprising about 15 per cent of our population who could provide themselves with adequate medical care without undue financial hardship; (2) a great middle class of employed, self-supporting, self-respecting persons, many of whom need financial assistance in paying for adequate medical care during times of serious or catastrophic illnesses; and (3) the indigent who are dependent upon tax money for all living costs, including medical care.

The Committees were convinced that the tenets of free choice of physician and non interference with the professional and confidential relationship between patient and physician are fundamental in providing any satisfactory solution for the problem. These are the principles through which the high medical standards in America are maintained. They stimulate the personal initiative of the individual physician and thus provide for the highest standard of medical practice. All Plans organized by the Society observe these fundamental tenets.

In the evolution of its program to meet the needs in New Jersey the Society has organized and placed in opera-

tion the following Plans: (1) The City of Newark Plan, coöperating with the City of Newark, operating for the past 18 months for the benefit of the financially indigent and medically indigent citizens of Newark; (2) Farm Security Medical Plan, coöperating with the United States Department of Agriculture, operating for the past three years for the benefit of low income farm families; (3) Medical-Surgical Plan of New Jersey offered to employed groups through the enrollment coöperation of Hospital Service Plan of New Jersey and providing under Medical-Surgical Plan contracts toward the cost of eligible medical, surgical, maternity, anesthesia and consulting services rendered its Subscribers and their enrolled Dependents admitted to hospitals for treatment.

The evolution of a Plan to meet the need of employed, self-supporting persons presents the most difficult problems. Their expressed need is for protection against the cost of serious or catastrophic illnesses. Their incomes vary from those with low incomes to those in high income brackets, and their need is in reverse ratio to their income. To meet these conditions the following steps were taken:

1. Serious or catastrophic illness was defined as an illness which is treated in a hospital. This definition applies to the vast majority of serious, unpredictable illnesses which are frequently catastrophic as affects the economic situation of the patient. It gave a definite group of illnesses for study regarding incidence and costs.

2. Very little material was available to our committees in determining the incidence of serious illnesses and the extent of existing defects among our population. The most reliable estimate was obtained from an analysis of 10,000 consecutive hospital cases served under the contract of Hospital Service Plan of New Jersey. All cases in this group were studied as to length of hospital stay, diagnosis, operative procedures, anesthesias, consultations and other types of professional services necessary in their care. To each of these services was assigned a modest fee, such as would ordinarily be payable by an employed self-supporting person of modest income. From this data our actuarial advisers were able to estimate a subscription rate of $.75 per month per employed person and $2.00 per month including family dependents as being reasonably adequate to support modest payments to physicians, providing the incidence of hospitalization and type of disease paralleled those of the study group.

3. Since the estimate of subscription rates was based upon amounts payable to physicians by patients of modest or low incomes, they should support complete payment for eligible services rendered subscribers of that economic group. This was attempted by Medical-Surgical Plan first on a basis of the type of hospital accommodations selected by the subscriber. Under the new contract as now being issued by the Plan, full coverage is determined in accordance with the income of the subscriber.

4. In basing complete payment upon type of hospital accommodations it was assumed that persons of low and modest income would choose ward or semi-private hospital accommodations and that persons of higher income would choose private room accommodations. Therefore, the first contract provided that Participating Physicians would deem as complete payment the amounts payable by the Plan for services rendered persons admitted for ward or semi-private accommodations; and as indemnity allowance toward the physician's bill for services rendered persons admitted for private room accommodations. This did not prove satisfactory for several reasons. Many persons with ample income chose semi-private accommodations, thus defeating the purpose of the arrangement. Hospitals, due to overcrowding and the increase in hospital costs have converted many of their single bed private rooms

into semi-private rooms of two or more beds, making fewer private rooms available at considerable increase in cost. The present contract, therefore, contains income limits as one determining factor between complete or partial payment for services rendered by Participating Physicians.

5. In determining these income levels a study was made of average incomes in New Jersey industry as of March 31, 1944. From the most reliable and authoritative sources information was received that the estimated income of employees of industry in New Jersey, including executives, was $1,875 per year; and that for "wage earners" in industry, exclusive of clerical and executive employees, the average income was $51.60 per week ($2,688 annually). The income limitation in the new contract of Medical-Surgical Plan of $2,000 for single person subscribers; and $2,000 for family subscribers, plus $500 for the wife or first enrolled dependent, plus $250 for each additional enrolled dependent (which would mean $3,000 in the instance of a married subscriber with wife and two children, an average sized family) as determining factors between full payment and partial payment are deemed consistent with these reported average incomes.

6. The term "income" as appearing in the contract of Medical-Surgical Plan can be interpreted only as gross income without any form of tax or other payroll deduction. The Society appreciates that income of the Subscriber may not be the only factor in determining his ability to pay for medical care. However, any other interpretation of the term "income" and determination of the ability of a Subscriber to pay for medical care must be a matter for determination between the patient and physician on a basis of confidential patient-physician relationship. After such a conference any amount payable to the physician by the Subscriber additional to the benefits under the Plan, will be such amount as the subscriber has agreed to pay the physician, and the Plan is not liable for any such excess.

During two years of experience in which the average admission rate to hospital among persons enrolled in Medical-Surgical Plan has been 91 per 1,000 per year the Plan has been able to pay physicians the following amounts as listed in its basic schedule of benefits for eligible services rendered in accordance with its contract, by-laws, rules and regulations. In addition to its basic schedule the Plan maintains in its office a "precedent" schedule. All items of eligible service not covered by a "precedent" are payable by a benefit determined by the Board of Trustees and that item becomes an item of the complete schedule applicable in future similar cases. The complete current schedule is available for inspection in the office of the Plan.

### I. MEDICAL BENEFITS

| | |
|---|---|
| Initial Hospital Visit | $ 5.00 |
| Hospital Visit on Subsequent Day | 3.00 |
| Subsequent Hospital Visits on same day, if approved by the Plan | 1.50 |
| Formal Consultation, if considered necessary and arranged for by attending physician | 10.00 |

### II. SURGICAL BENEFITS

#### ABDOMEN

| | |
|---|---|
| Appendectomy | 100.00 |
| Gall Bladder, removal | 125.00 |
| Stomach Resection | 150.00 |
| Stomach Ulcer, closure of perforation | 125.00 |
| Hernia repair, recurrent, ventral or both sides | 100.00 |
| Inguinal or Femoral Hernia Repair | 75.00 |
| Intestinal resection | 150.00 |
| Cutting operations into abdominal cavity unless otherwise specified in complete schedule | 100.00 |

#### ABSCESS

| | |
|---|---|
| Deep Cellulitis of Neck, incision and drainage | 50.00 |
| Ischio-Rectal Abscess, incision and drainage | 50.00 |
| Breast Abscess, incision and drainage | 25.00 |
| Superficial Abscesses, incision and drainage | 10.00 |

## ANESTHESIA

| | |
|---|---|
| Anesthesia, general or spinal | 10.00 |

## BREAST

| | |
|---|---|
| Radical Amputation | 100.00 |
| Radical Amputation, bilateral | 150.00 |
| Simple Amputation | 65.00 |
| Excision of non malignant tumor | 50.00 |

## CHEST

| | |
|---|---|
| Thoracoplasty, first stage | 100.00 |
| Thoracoplasty, subsequent stage | 50.00 |
| Bronchoscopy, including biopsy | 75.00 |
| Bronchoscopy, subsequent | 25.00 |
| Empyema, closed drainage of | 50.00 |
| Empyema, rib resection for | 50.00 |
| Phrenic Nerve, crushing or evulsion | 50.00 |

## CHILDBIRTH

(See Maternity)

## CYSTS — SUPERFICIAL

| | |
|---|---|
| Pilonidal Cyst or Sinus, excision | 50.00 |
| Ganglion Cyst, excision | 35.00 |
| Cyst, sebaceous (wen) excision | 10.00 |
| Cysts, sebaceous, multiple, excision | 20.00 |

## EAR, NOSE AND THROAT

| | |
|---|---|
| Antrum, Caldwell-Luc operation | 75.00 |
| Antrum, Canfield operation | 65.00 |
| Submucous Resection of Nasal Septum | 50.00 |
| Tonsillectomy | 40.00 |
| Incision of Ear Drum | 10.00 |
| Sinus Puncture and Treatment | 10.00 |

## EYE

| | |
|---|---|
| Cataract, removal of | 100.00 |
| Strabismus, complicated, operation for | 100.00 |
| Strabismus, simple, operation for | 50.00 |
| Enucleation of Eye | 50.00 |
| Chalazion of lid, excision of | 10.00 |

## FRACTURES

| | |
|---|---|
| Skull, non operative, payable on medical basis | |
| Nose | 15.00 |
| Forearm, both bones | 35.00 |
| Upper Arm, Shaft | 50.00 |
| Thigh | 75.00 |
| Lower Leg, tibia | 50.00 |
| Lower Leg, both bones or Pott's Fracture | 75.00 |
| Clavicle | 25.00 |
| Metacarpal, single | 20.00 |
| Metacarpal, more than one | 30.00 |
| Finger, or great toe | 15.00 |
| Toe, other than great toe | 10.00 |

For fractures requiring treatment by open operation, traction and extension, Kirschner wire or Pins, add 100 per cent, but in no case, for single or multiple fractures shall the benefit payable by the Plan exceed $150.00.

## GENITO URINARY TRACT

| | |
|---|---|
| Kidney Removal | 150.00 |
| Prostate, removal, suprapubic | 150.00 |
| Prostate, removal, perineal | 100.00 |
| Prostatectomy, transurethral resection | 100.00 |
| Ureter, anastomosis | 150.00 |
| Cystoscopy, operative | 50.00 |
| Cystoscopy, with pyelogram | 35.00 |
| Cystoscopy, diagnostic | 25.00 |
| Hydrocele, excision of | 50.00 |
| Varicocele, excision | 50.00 |
| Circumcision, adult | 15.00 |
| Orchidectomy | 50.00 |

## GOITER

| | |
|---|---|
| Thyroidectomy | 125.00 |

## GYNECOLOGY

| | |
|---|---|
| Hysterectomy, complete (abdominal) | 150.00 |
| Hysterectomy, supra vaginal (abdominal) | 125.00 |
| Hysterectomy (removal of uterus) vaginal | 125.00 |
| Vaginal Repair and Abdominal Procedure. | 125.00 |
| Prolapse of Uterus, Manchester or Interposition operation | 125.00 |
| Uterine Displacement, abdominal correction | 100.00 |
| Fistula, vesico-vaginal, with anterior colporrhaphy | 100.00 |
| Cervico-Vaginal Repair, more than two procedures | 100.00 |
| Amputation of Cervix | 50.00 |
| Amputation of Cervix and Perineorrhaphy | 75.00 |
| Perineorrhaphy | 50.00 |
| Dilatation and Curettage | 25.00 |
| Dilatation and Curettage, postabortive | 35.00 |

## MATERNITY

| | |
|---|---|
| Normal, spontaneous delivery | 50.00 |
| Caesarean Section | 100.00 |

Maternity benefits are eligible only if and as provided in the Subscription Contract. In any event, benefits are not payable for services rendered prior to hospital admission or after hospital discharge.

## PROCTOLOGY

| | |
|---|---|
| Hemorroidectomy, External | 35.00 |
| Hemorroidectomy, external and internal. | 50.00 |

| | |
|---|---|
| Anal Fistulectomy | 50.00 |
| Fissurectomy | 25.00 |
| Abscess, ischio-rectal, incision and drainage with after care | 50.00 |
| Carcinoma of rectum, extirpation | 150.00 |

TRANSFUSION

(Exclusive of cost of blood, plasma or serum)

| | |
|---|---|
| Transfusion, limited to 2 per hospital admission, each | 25.00 |
| Plasma or Serum, intravenously | 10.00 |

TUMORS — SUPERFICIAL

| | |
|---|---|
| Tumor, malignant of skin, wide excision | 50.00 |
| Tumor, non malignant of skin or subcutaneous lipoma, excision | |
| Single | 10.00 |
| Multiple | 20.00 |

VARICOSE VEINS

| | |
|---|---|
| Ligation of Saphenous including necessary branches | |
| Bilateral | 75.00 |
| Unilateral | 50.00 |

## DISTRIBUTION OF MEDICAL CARE

Organized medicine cannot prevent the establishment of socialized medicine unless it offers a satisfactory alternative. We in New Jersey believe that we have found a practical solution and that our principles and methods are uniformly applicable to all parts of the United States with slight modifications required to meet conditions existing in individual states and communities. Our principles are well founded and we can take pride in the knowledge that we have implemented them in a logical and efficient manner.

Our Society has endorsed the principles that: Every man, woman and child in the American Commonwealth is entitled to the four essentials of life, i. e., food, clothing, shelter and medical care; that medical care must be made available to everyone at a cost that he can afford to pay; that voluntary health plans must be developed to aid people of moderate income who may need help in meeting the expenses of catastrophic illness; that medical care must be provided for indigent and medically indigent persons by the government by means of tax subsidies, the distribution of medical care for this group being administered on a state or local level with funds provided by Federal, State or Municipal Agencies.

At the present time, the Government is providing food, clothing and shelter for the needy on a subsidized basis. To date no suggestion to socialize the distribution of these three essentials has even been suggested. Why, therefore, should the fourth essential, Medical Care, be socialized?

Two large groups of physicians allegedly independent of the American Medical Association, have been organized to combat the proposed socialization of medicine. The National Physicians Committee has done excellent work in presenting the objections to socialized medicine but has offered no alternative. The American Association of Physicians and Surgeons of Gary, Indiana, has also taken a negative position in attempting to forestall socialization of medicine by the use of what is known as the "secondary boycott" without offering any constructive suggestions for the solution of the problem of the distribution of medical care.

The Medical Society of New Jersey, on the other hand, has a positive program which it has been developing since 1939. It has established the Medical-Surgical Plan of New Jersey, which provides for the payment for medical and surgical services rendered to subscribers or their dependents who require medical or surgical treatment in a hospital. This organization is a non-profit medical service plan organized by our Society. It represents a successful venture in the field of voluntary health insurance. It is growing rapidly and we expect that in a few years it will be as helpful to our people as the Hospital Service Plan of New Jersey has been. Another corporation, the Medical Service Administration, was also organized by The Medical Society of New Jersey to provide medical care for the indigent and medically indigent groups. The Medical Service Administration has carefully studied all aspects of the problem of medical care for the needy and has accumulated many data and has done much pioneering work in this field. At the present time it is providing medical care for low income people in the farming communities through the Farm Security Administration. By agreement with the City of Newark, it is arranging for the payment of physicians for services rendered to the indigent and medically indigent people in that City. The Medical Service Administration hopes to develop this service in other communities throughout the State.

# ORIGINAL ARTICLES

## FATAL REACTION FOLLOWING THE INTRAVENOUS INJECTION OF MERCUPURIN *

### A Review of the Literature and Report of a Case in Which a High Environmental Temperature Was a Contributing Cause

S. Ben-Asher, M.D., Jersey City, N. J.

Within recent years a number of fatalities following the intravenous use of mercurial diuretics have been reported in the literature. Thus, Wolf and Bongiorno [1] reported in 1931 a death after the intravenous injection of salyrgan in a child with nephrosis. In 1934, Sundaram [2] also reported a fatality after the intravenous injection of salyrgan in a child with rheumatic heart disease. A fatality following an intravenous injection of salyrgan in a case with nephritis was reported by Cadbury [3] in 1936. Two fatalities following the injection of salyrgan intravenously in cases with nephrosis were described by Greenwald and Jacobson [4] in 1937. In 1941, Tyson [5] reported a death after the intravenous administration of mercupurin in a patient with nephrosis. Brown, Friedfeld, Kissin, Modell and Sussman [6] reported in 1942 four deaths following the intravenous use of mercupurin in patients with cardiac decompensation. Four more fatalities after the intravenous use of salyrgan plain, salyrgan and theophyllin, and mercupurin were described in the same year by Barker, Lindberg and Thomas.[7] Finally, Wexler and Ellis [8] reported in 1944 one death following the administration of mercupurin in a case with congenital pulmonary stenosis who had chronic cardiac failure, and another fatality in a case with nephrosis.

In addition to the above fatal accidents, nonfatal reactions have been described by Wexler and Ellis [8] as either immediate or delayed, which may be either of mild or serious nature.

The purpose of this communication is to report another fatality following the use of mercupurin, in which a high environmental temperature was a contributing cause. In addition, the incidence, pathogenesis, clinical manifestations, and the prevention of reactions will be discussed.

#### INCIDENCE

Considering the extensive use of mercupurin, the number of deaths reported from its use is very small. DeGraff and Nadler [9] state that approximately 6,000 injections of mercupurin have been given each year in Bellevue Hospital since 1934 with no serious toxic reactions nor deaths which might be attributed to the drug. The two fatal cases reported by Wexler and Ellis [8] occurred in a series of 5,200 injections during a six-month period. While comparative figures are not available, it can be stated that the mortality attributable to the mercurial diuretics does not appear greater, and is probably lower, than in other potent drugs which are employed with equal frequency.

#### PATHOGENESIS

The exact mechanism of these reactions is not known. Postmortem examinations have failed to disclose the cause of death. Instances of hypersensitiveness to mercupurin intravenously and mercurin suppositories with fever,

* From the Cardiac Clinic and Medical Department, Medical Center, Jersey City, N. J.

1. Wolf, L. J., and Bongiorno, H. C.: Sudden death with salyrgan. Canad. A. M. J. 25:73, 1931.
2. Sundaram, S. K.: Idiosyncrasy to salyrgan. Correspondence. J. A. M. A. 103:60, 1934.
3. Cadbury, W. W.: Idiosyncrasy to salyrgan. Medical papers dedicated to H. W. Christian, 1936, Baltimore, The Waverly Press, pp. 259-260.
4. Greenwald, H. W., and Jacobson, S.: Sudden death due to mercurial diuretics. J. Pediat. 11:540, 1937.
5. Tyson, M. C.: Danger of intravenous mercurial injections in nephrosis. J. A. M. A. 117:998, 1941.
6. Brown, G.; Friedfeld, R.; Kissin, W.; Modell, W., and Sussman, R. M.: Deaths immediately following the intravenous administration of mercupurin. J. A. M. A. 119:1004, 1942.
7. Barker, M. M.; Lindberg, H. A., and Thomas, M. E.: Sudden death and mercurial diuretics. J. A. M. A. 119:1001, 1942.
8. Wexler, J., and Ellis, L. B.: Toxic reactions to the intravenous injection of mercurial diuretics. Am. Heart J. 27:86, 1944.
9. DeGraff, Arthur C., and Nadler, J. Ernest. A review of the toxic manifestations of mercurial diuretics in man. J. A. M. A. 119:1006, 1942.

erythema and exfoliative dermatitis have been described.[10] The fact that some fatalities occurred in instances when previous injections did not produce any reactions has led Greenwald and Jacobson [11] to consider them as anaphylactic in nature. The previous injections, they believe, might have sensitized the patient to the fatal reaction. This theory, however, does not explain the fatalities that have occurred following the first injection.

In some cases, the toxic manifestations appear to be due to a direct action of the mercurial diuretic on the heart muscle. This theory receives support from some laboratory and clinical evidence. Salant and Kleitman [12] were the first to observe ventricular fibrillation in normal dogs following the intravenous administration of inorganic mercurial salts. Later, Jackson [13] demonstrated that fibrillation and death could be produced in normal dogs by the intravenous injection of 5 c.c. of a 2 per cent solution of salyrgan. Chastan and Mackie [14] also showed that esidrone injected intravenously in normal dogs will produce changes in the electrocardiogram followed by ventricular flutter, fibrillation and death. Similar results were obtained recently by Barker, Lindberg and Thomas [7] with various mercurial salts. Clinically, the occurrence of extra systoles and tachycardia, which disappear after 5 to 10 minutes, is often observed immediately following the injection of the mercurial diuretics. It is thus possible that some of the fatal reactions may have been due to the action of the mercury on the ventricular muscle.

Toxic reactions may also occur as a result of a disturbance in the water and electrolyte equilibrium of the body induced by the mercurial diuretics. Soon after their introduction of novarsurol as a diuretic, Saxl and Heilig [15] showed that diuresis is accompanied by an absolute increase in the chlorides of the urine. Later Crawford and McIntosh [16] found that the increase in the chloride excretion in the urine is accompanied by a fall in the serum chloride. Blumgart and his co-workers [17] demonstrated that diuresis is accompanied by an increased secretion of chloride, sodium and potassium. The amount of chloride in the extra urine excreted is greater than that of an equal volume of body fluid. This increased secretion of inorganic ions is accomplished by a relative decrease in tubular reabsorption, the rate of glomerular filtration remaining unaffected. Diuresis is also accompanied by a decrease in the serum chloride concentration which, they believe, is a consequence of the excess urinary chloride loss, and by an approximately equivalent rise in the serum bicarbonate concentration. The serum concentration of sodium and calcium is unchanged.

Chabanier, Lebert and Lumiere,[18] however, found a drop in the blood sodium and chloride. Keith, Barrier and Whelan [19] also found increased secretion of sodium following novarsurol in cases of nephritis with edema. The changes in the concentration of the inorganic ions of the blood were inconstant and never marked in degree.[20] Poll and Stern [21] reported seven cases exhibiting toxic reactions to mercurial diuretics which, they believe, were due to a loss of sodium, similar to the acute collapse seen in Addison's disease. These inconstant and conflicting findings may be explained by the fact that while the mercurial diuretics produce a decrease in tubular reabsorption with no change in glomerular filtration, dehydration produces the opposite effect; i. e., an increased tubular reabsorption and a decrease in glomerular filtration.[22] Hence the results

10. Fox, T. T.; Gold, H., and Leon, J.: Hypersensitiveness to mercurial diuretics. J. A. M. A. 119:1497, 1942.
11. Greenwald, H. M., and Jacobson, S.: Sudden death due to mercurial diuretics. J. Pediat. 11:540, 1937.
12. Salant, W., and Kleitman, N.: Observations on the action of mercury. J. Pharmacol. and Exper. Therap. 19:315, 1922.
13. Jackson, D. E.: Action of mercury in organic combination. J. Pharmacol. and Exper. Therap. 29:471, 1926.
14. Chastan, L. L., and Mackie, G. C.: Studies on toxicity of new mercurial diuretic (Sodium salt of Pyridine-dicarboxy-mercuri-hydroxyl-hydroxyl-propyl-amide-theophyllin). South. Med. and Surg. 102:5, 1940.
15. Saxl, P., and Heilig, R.: Ueber die diuretische wirkung von novarsurol und anderen quecksilbering jektionen. Wien. Klin. Wchnschr., 33:943, 1920.
16. Crawford, J. Hamilton, and McIntosh, J. F.: Observation on the use of novarsurol in edema due to heart failure. J. Clinical Investigation 1:333, 1922.
17. Blumgart, H. L.; Gilligan, D. R.; Levy, R. C.; Brown, M. G., and Volk, M. C.: Action of diuretic drugs. Arch. Int. Med. 54:40, 1934.
18. Chabanier, H.; Lebert, M., and Lumiere, F.: Analyse Physiologique de Laction du 449B (ou neptal). Bull. Soc. Franc. durol., 6:259, 1927.
19. Keith, Norman H.; Barrier, Charles W., and Whelan, M.: The diuretic action of ammonium chloride and novarsurol in cases of nephritis with edema. J. A. M. A. 85:799, 1925.
20. Keith, N. M., and Whelan, M.: A study of the action of ammonium chloride and inorganic mercury compounds. J. Clin. Investigation 3:149, 1926.
21. Poll, Daniel, and Stern, J. E.: Dangers of dehydration treatment in heart disease. M. Clin. North America 21:1873, 1937.
22. Klinghoffer, K. A.: Dehydration from diuretics. New Internat. Clin. Vol. 1, series 4, 221-226, 1941.

may vary in different cases and in the same patient at different times.

Lyons and his associates [23] have shown that dehydration is accompanied by a fall in the plasma volume associated with a fall in venous pressure and pulse pressure. Coincident with the fall in the plasma volume there is a decrease in the serum protein and a rise in the hematocrit.

Excessive loss of chloride will produce symptoms such as are seen in cases of alkalosis. Excessive loss of sodium may produce symptoms of shock as in Addison's disease. As a result of marked hemoconcentration, vascular collapse and death may follow, because of a diminished return flow to the heart and a fall in the cardiac output.

Hyman [24] believes that the reactions to the mercurial diuretics are technical rather than hemodynamic and resemble the syndrome of speed shock in which the blood is rendered non-coagulable when any material is rapidly injected intravenously. The symptoms of speed shock occur immediately after injections and consist of salivation, vomiting and diarrhea, irregular respiration, fall in blood pressure, and bronchospasm. In a study on the influence of velocity on the response to intravenous injections, Hirshfeld, Hyman and Wanger [25] state that solutions with larger molecules should be given more slowly than solutions with smaller molecules and that toxic substances should be given intermittently as well as slowly.

Lastly, digitalis toxicity may occur following the administration of the mercurial diuretics as a result of the mobilization of digitalis from the retained tissue fluids. This is, however, seldom serious and disappears spontaneously after the cessation of digitalis.

## CLINICAL MANIFESTATIONS

The reactions may be fatal and non-fatal. Wexler and Ellis [8] have divided the non-fatal cases into immediate and delayed types. The immediate fatal and non-fatal reactions are characterized by dyspnea, cyanosis or pallor, irregular breathing, drop in blood pressure, cardiac irregularity, unconsciousness, and convulsions. Cardiac arrest may occur before respiratory paralysis within five minutes after the injection.

Mild, non-fatal, immediate reactions may be manifested by a sense of apprehension, substernal discomfort, transient dyspnea, orthopnea, cyanosis, sweating, and tachycardia.

Delayed reactions occur one to two hours after the injection and with symptoms of asthma or pulmonary edema.

Hypersensitiveness may present itself with symptoms of fever, erythema, parasthesia and ulcerative stomatitis.

## PREVENTION OF REACTIONS

It is generally stated that there is no known way of avoiding a reaction. The presence of kidney disease is considered a contra-indication to the use of the mercurial diuretics, although one may have to resort to its use in spite of impaired kidney function. From experiments on cats, DeGraffe and Lehman [26] conclude that toxic reactions cannot be avoided by dilution of the drug nor by slow injection. Clinically, I have encountered instances of mild reactions which did not recur on subsequent injections when the solution was given slowly and intermittently. Barker, Lindberg and Thomas [7] emphasize caution in the intravenous use of the mercurials in the water-logged patient. High environmental temperature may also be added to the list of the contra-indications.

## CASE REPORT

M. B., female, white, married, age 55, was admitted to the Medical Center July 25, 1943, because of headache, dizziness, extreme restlessness and anuria.

*Previous History:* She had chorea at eleven and rheumatic fever at the age of fifteen. Two years prior to admission, she began to have symptoms of congestive failure. She was treated at the cardiac clinic, where she was digitalized and an intravenous injection of 1 c.c. of mercupurin administered. Five grams of ammonium chloride were also prescribed, but this was discontinued because of nausea and gastric distress. In the following two years she received at the clinic a total of ninety-two injections of 2 c.c. of mercupurin at weekly intervals.

23. Lyons, R. H.; Avery, N. L., and Jacobson, S. D.: Effect of dehydration, produced by mercupurin, on the plasma volume of normal persons. Amer. Heart Jour. 28:247, 1944.
24. Hyman, H. T.: Sudden death after use of mercurial diuretics. Communication J. A. M. A. 119:1444, 1942.
25. Hirshfeld, S.; Hyman, H. T., and Wanger, J. J.: Influence of velocity on the response to intravenous injections. Arch. Int. Med. 47:259, 1931.
26. DeGraffe, Arthur C., and Lehman, Robert A.: The acute toxicity of mercurial diuretics. J. A. M. A. 119:998-1001, 1942.

There was no toxic reaction following any of the injections.

*Present Illness:* The last injection was given ten hours before entry. On that day the official temperature reached a maximum of 96° and the humidity was 86 per cent. Three hours after the injection, the patient became irritable and complained of headache and dizziness. She stated that "this time the needle did not work so well". She developed oliguria, followed by anuria, and was admitted to the Medical Center ten hours after the injection.

*Physical examination* disclosed a restless middle-aged woman with frequent generalized muscular tremors. There was cyanosis of the mucous membranes. The tongue was dry. Examination of the heart revealed the P. M. I. to be in the fifth interspace, outside the midclavicular line. The rhythm was totally irregular. Systolic and diastolic murmurs were heard at the apex. $P_2$ was greater than $A_2$ and was accentuated. Moist crepitant râles were heard at the bases of both lungs. The abdomen was distended, the liver four fingers below the right costal margin. There was no evidence of ascites. There was a slight amount of pitting edema of the legs. There was a positive Chvostek's sign. The temperature was 104.2. The blood pressure was 90 systolic and 60 diastolic. The ventricular rate was 154 and the radial pulse 128.

On catheterization only 30 c.c. of urine was obtained, which contained a trace of albumin, no red cells, four white cells and no casts. The specific gravity was 1.026.

The blood count showed a white cell count of 11,200 with a normal differential count. There were 5,860,000 red cells per cu. m.m. and the hemoglobin was 96 per cent.

The blood chemistry revealed an N. P. N. of 40 mg.; sugar 128 mg.; chloride 360 mg.; and a total protein 9.2 gm. per 100 c.c.; $CO_2$ 83 vol. %.

The patient was given an infusion of saline and glucose. She soon became stuperous, the respiration became rapid and the pulse imperceptible. She expired one hour after admission.

At postmortem examination no immediate cause of death could be found. The heart showed mitral disease with cardiac enlargement.

## COMMENT

Reviewing the literature of the reported fatalities, it can be noted that the largest proportion of the fatalities occurred among patients with evident kidney disease in which the use of the mercurial is considered to be contra-indicated. It can be noted also that in all cases death occurred within five minutes after the injection, except in one instance. In this case the drug was given slowly by the gravity drip method, and the reaction took place after thirty minutes, while the solution was still running. Also, all cases except three exhibited reactions after previous injections. From these reports and from experimental evidence it is clear that in cases of immediate reactions, the cause of death can be ascribed to a direct action of the mercury on the heart muscle. In the delayed non-fatal reactions, however, the associated diuresis is probably the cause.

In the case presented here, the fatality occurred eleven hours after the injection. Ninety-two previous injections failed to produce any reactions. After the last injection, administered during a high environmental temperature, the patient developed anuria, fever and muscular tremors. There was evidence of hemoconcentration with a fall in the serum chloride. She died with symptoms of vascular collapse.

It is evident that the dehydration induced by an excessive loss of inorganic ions by the sweat glands was further increased by the mercupurin. The muscular tremors, positive Chvostek's sign and increased $CO_2$ indicate a state of alkalosis due to a loss of chlorides. Unfortunately, the serum sodium was not determined and it is possible that this, too, may have been low.

Theoretically, it would seem that a reaction could be predicted by a chemical analysis of the blood before the injection. Were this a practical procedure, a normal result would not eliminate the presence of dehydration, since in its early stages normal patterns are usually maintained.[22] One may also presume that the administration of sodium chloride and water before injection might restore the electrolyte and water balance of the body. However, the value of dehydration therapy under these conditions is questionable.

The mercurials are valuable therapeutic drugs and frequently indispensable in the treatment of congestive heart disease. Observance of known contra-indications may not eliminate the danger of fatalities. However, the usefulness of the drugs far outweighs its dangers, and the possibility of a reaction should not deter one from its use when indicated.

## SUMMARY

A fatality following the intravenous injection of mercupurin is reported. An alteration in the electrolyte balance, brought about by a high environmental temperature and mercurial diuresis, was the apparent cause.

TABLE SHOWING REACTION TO MERCURIAL DIURETICS DESCRIBED IN THE LITERATURE

| Author and Year | No. of Cases | Diagnosis | Age | Diuretic Used and Amount | Interval Between Injection and Reaction |
|---|---|---|---|---|---|
| Wolf and Bongiorno 1931 | 1 | Nephrosis | 5 | 1 c.c. salyrgan | 1 min. |
| Sundaram—1934 | 1 | Rheumatic heart disease | 10 | .5 c.c. salyrgan | 5 min. |
| Cadbury—1936 | 2 | Nephritis | 21 | 2 c.c. salyrgan | 5 min. |
| | | Nephritis | 5 | .6 c.c. salyrgan | 10 min. |
| Greenwald and Jacobson—1937 | 2 | Nephrosis | 2 | 1 c.c. salyrgan | 1 min. |
| | | Nephrosis | 3 | .5 c.c. salyrgan | 5 min. |
| Tyson—1941 | 1 | Nephrosis | 3 | 1 c.c. mercupurin | 1 min. |
| Barker, et al.—1942 | 4 | Syphilitic aortitis. Coronary heart disease | 59 | 2 c.c. salyrgan | 2 min. |
| | | Chronic glomerular nephritis | 48 | 2 c.c. mercupurin | 5 min. |
| | | Arteriosclerosis of kidney Cardiac hypertrophy | 64 | 4 c.c. salyrgan and theophyllin | 2 min. |
| | | Arteriosclerosis of kidney Cardiac hypertrophy | 64 | 1 c.c. salyrgan | 30 min. solution running |
| Brown, et al.—1942 | 4 | Coronary heart disease | 68 | 2 c.c. mercupurin | 1 min. |
| | | Hypertension. Coronary heart disease | 52 | 2 c.c. mercupurin | 3 min. |
| | | Syphilitic heart | 48 | 2 c.c. mercupurin | 10 min. |
| | | Hypertension. Coronary heart disease | 60 | 2 c.c. mercupurin | 4 min. |
| Wexler and Ellis 1944 | 2 | Congenital pulmonary stenosis | 24 | 3 c.c. mercupurin | 2 min. |
| | | Nephrosis | 27 | 2 c.c. mercupurin | 3 min. |

## RESOLUTION ON THE MISUSE OF BARBITURIC ACID DERIVATIVES

J. LYNN MAHAFFEY, M.D., Director of Health
State of New Jersey, Department of Health

At a meeting of the Department of Health of the State of New Jersey held on May 15, 1945, it was on motion voted that the following resolution be adopted:

*Whereas,* A recent study of death certificates by the Bureau of Foods and Drugs of the New Jersey State Department of Health has revealed that there is in this State an increasing number of accidental deaths resulting from the misuse of barbituric acid derivatives, and

*Whereas,* The results of the study have moved the State Department of Health to take cognizance of the increasing danger to the public health resulting from such misuse of the aforesaid drugs, therefore be it

*Resolved,* That this Department issue to the members of the Medical profession of New Jersey, through The Medical Society of New Jersey, a warning as to the possible misuse of barbituric acid derivatives, and

*Be It Further Resolved,* That this Department specifically suggests that prescriptions for the aforesaid drugs not intended for renewal, be marked "Not to be renewed", at the time they are issued.

# FURTHER EVIDENCE OF THE RELATIONSHIP BETWEEN HERPES ZOSTER AND VARICELLA

E. Clarence Kern, M.D., Montclair, N. J.

Another indication that herpes zoster and varicella are allied came to my attention in February, 1945, in treating Miss F, aged 81, of Montclair, N. J. Miss F, who lives alone and seldom leaves her rooms, had occasion to visit and care for a small boy who had just recovered from chicken pox. She held the boy on her lap and read to him for several hours. She noticed that the child still had some conjunctival irritation and photophobia. This was on February 2. On February 8 she noticed a painful red area on the right side of her forehead. On February 10, when she came to me, she had a typical herpes zoster involving the right supra-orbital region. The affected area extended exactly to the midline, a short distance into her hair laterally and, below, to the middle of her right cheek. There was some conjunctival injection, a slight cloudiness of the cornea and a very slight ciliary injection. Treated with 1 c.c. pituitrin t.i.d. and occasional drops of atropine in the involved eye, the patient made a very satisfactory improvement. Pain disappeared in five days. After two weeks there was but a small amount of scabbing and a moderate degree of scarring.

The theory that herpes zoster and varicella are related is comparatively new, having first been advanced about 20 years ago. Kundratiz, 1924, suggests that one frequently confers an immunity against the other. In this connection it is interesting to note that Miss F. had never had chicken pox. It is probable that chicken pox in children may be transmitted to adults as herpes zoster and, reversely, that herpes zoster in adults may be transmitted to children as chicken pox. In any event, doctors treating either disease should warn those close to the patient of its infectious nature, and, in particular, point out to older persons the danger of contracting herpes zoster after exposure to chicken pox.

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# GOLD IN ARTHRITIS

If gold is to be effective in arthritis, says the *British Medical Journal* editorially, it must be given in a form which is easily absorbed and which will remain in the circulation long enough to reach the site where it will exert its action. Such conditions are probably best obtained by intramuscular injections of the water-soluble gold salts. These drugs are potentially toxic and are retained in the body for a long time after the period of administration. As there is no known method of inhibiting the toxic action, which may appear late in the treatment when the patient has large amounts of gold in his system, it is essential to restrict dosage to the smallest amount known to be effective. When crystalline salts are used the equivalent of 25 mg. gold weekly, which in the case of myocrisin is contained in 50 mg. of the salt, is the minimal effective dose, and the total quantity of gold given should not exceed one gram. Using this amount, the incidence and severity of the toxic reactions fell from 41 to 17 per cent, and there were no cases of nephritis, exfoliative dermatitis, or other severe reactions. Smaller doses appeared to be less effective in the treatment of arthritis, and colloidal gold sulphide gave little or no benefit. So far no dosage of gold can be recommended which is both therapeutically effective and yet below the level of toxicity. This makes it all the more important that only cases likely to obtain benefit should be selected for this treatment, and it is difficult to do this, as it is still unknown where, how, or why gold salts work. Major errors can be avoided if it is realized that the only possible action of gold is to lessen or arrest inflammation. No benefit can be expected in osteo-arthritis, which is a degenerative non-inflammatory joint disease, or in old-standing rheumatoid arthritis with irreversible bone and joint changes. Only patients in the active inflammatory stage of rheumatoid arthritis are suitable candidates for the treatment; and even in them improvement is uncertain, and there is always a risk of toxic complications.—Philadelphia Medicine.

# A BETTER TEST MEAL

M. A. Ogden, M.D., Passaic, N. J.
Pathologist and Director of Passaic General Hospital and Ogden Clinical Laboratories

For the purpose of simplifying the procedure of fractional gastric analysis and at the same time attaining accurate results, I found the following test meal to have advantages over any test meal, to my knowledge, so far proposed.

Patient reports for examination early in the morning on a fasting stomach.

1. Prepare 600 cc. of plain fresh beef broth. Remove excess of fat and boil, preferably in graduated pyrex beaker, to evaporate to one-fourth of this volume, i. e., 150 cc. This should have body temperature.

2. Measure in the separate cup 150 cc. of drinking water.

3. After the local anaesthesia of the throat attained by swabbing it with novocain-suprarenin solution, and oiling the stomach tube with small amount of mineral oil, introduce the tube into the stomach. To make easier passage of the tube allow the patient to swallow tap water not in excess of 150 cc.

4. Obtain from 5 to 25 cc. of gastric contents representing a fasting specimen.

5. Inject 150 cc. of concentrated broth through *the stomach tube.*

6. Obtain specimens every 15 minutes for one and half to two hours.

7. After obtaining the last specimen wash the stomach with 300 to 400 cc. of the tap water.

The advantages of this test meal are as follows:

1. It completely *eliminates chewing of the food* as is done in nearly every test proposed.

2. Due to the concentration of the broth, it contains a sufficient amount of the extractive and nutritive substances stimulating excretory gastric acidity.

3. It prevents displacement of the tube as there is *no necessity for swallowing the food.* The latter act also produces an excessive salivation and, thus, as nearly in all tests so far proposed, decreases the accuracy of the test.

4. It is soothing to the stomach and avoids irritation which I have observed in numerous patients while giving an alcoholic meal.

5. It does not introduce an artificial stimulation, as is the case with the histamine meal.

6. By this method the stomach tube is *passed only once,* while in a number of other methods, after the fasting specimen is obtained the tube is passed a second time or a rather complicated procedure of feeding the patient with the tube *in situ* is followed. This latter procedure diminishes the accuracy of the test, because even if few exceptionally tolerant patients attempt to chew their meal with the tube in the esophagus, there is as a rule excessive salivation and there is always a possibility of displacing the tip of the tube, thus impairing the accuracy of the test.

7. Finally, in view of the passage without any difficulty or discomfort, of the whole test meal, through the stomach tube, using *this test meal,* there is a better chance to retain the tip of the tube at the proper site in the stomach, thus increasing the *accuracy of the final results.*

## NEW JERSEY RADIOLOGICAL SOCIETY OFFICERS

At the annual meeting of the Radiological Society of New Jersey held on May 16, 1945, the following members were elected as officers for the Society:

President, Dr. H. J. Perlberg, Jersey City
Vice-President, Dr. John Olpp, Englewood
Secretary, Dr. H. R. Brindle, Asbury Park
Treasurer, Dr. W. H. Seward, Orange
Councillor to the Radiological Society of New Jersey, Dr. W. E. Pottinger, Morristown
Councillor to the American College of Radiology, Dr. J. H. Wyatt, Newark.

# STATE ACTIVITIES

## DR. EDWARD W. SPRAGUE RECEIVES THE EDWARD J. ILL AWARD

On Thursday, May 17, 1945, at the Annual Meeting of the Academy of Medicine of Northern New Jersey, a large and representative audience, from all walks of life, witnessed the bestowal of the Edward J. Ill Award on Dr. Sprague.




THE EDWARD J. ILL AWARD



DR. HENRY C. BARKHORN, DR. ROYAL A. SCHAAF, DR. HARRISON S. MARTLAND, DR. EDWARD W. SPRAGUE

### REMARKS BY DR. ROYAL A. SCHAAF, PRESIDENT

In 1939, during the Presidency of Dr. Henry C. Barkhorn, the Academy of Medicine of Northern New Jersey established the Edward J. Ill Award in recognition of the outstanding professional attainments of the man for whom it was named. The original description of the Award is as follows: "This Award shall be given at such times as the Council deems wise to that Doctor from Northern New Jersey who merits it for his extraordinary services as a physician and as a citizen." The Award has been made on six previous occasions, each time to a man distinguished for his professional attainments and his contribution to the public welfare. Of the six, five are still living and four are with us tonight. As the years elapse, the Award will assume increasing dignity and importance and will become one of our most valued traditions. The Award need not necessarily be made each year and the likelihood is that it will be made with diminishing frequency as time goes on. In the early years there were a number of candidates who fully deserved it and future candidates may not be numerous because of the rigid requirements of the original provision.

The candidate for the Award tonight, Dr. Edward W. Sprague, by reason of his attainments as a surgeon and his contribution to the public welfare, merits it fully as much as any of his predecessors. The citation for Dr. Sprague will be made by a previous recipient of the Award. It is my privilege to present Dr. Henry C. Barkhorn.

## CITATION BY DR. HENRY C. BARKHORN

Edward Sprague was born in northern New York near Lake Ontario; he studied medicine in Baltimore and interned at the Newark City Hospital. Here he developed the friendships which have been an integral part of his life ever since. He is a man whom we have all learned to know with intimacy and ever increasing affection as the years have passed.

He is a great man, a fitting physician to join the fellowship of the group who have previously received the Edward J. Ill Award. He has the sympathy and understanding, the hatred of injustice and the capacity to discuss and solve problems that led to his being called by the Welfare Federation to succeed Dr. Eagleton and by the Prudential Insurance Company to succeed Dr. Edward J. Ill.

A courageous surgeon, he has, in turn, given many potential surgeons of the younger group opportunities they could not possibly have had under any other mechanism or under any other teacher. His loyalty to this group and to the hospitals in which he does most of his work, Newark City, Babies (Coit Memorial), St. James and Presbyterian, is outstanding and has led, in great measure, to their representative place in the welfare of the community.

Dr. Sprague was an early proponent of the Medical Service Plans, but, being a modest man, he always gave credit to others for the development of these projects which are surely a partial solution for adequate medical care instead of undemocratic governmentally controlled medicine as planned by other groups.

His great enthusiasm for social welfare was the prime reason for the fee for service phase of the hospital committee allotments through the Welfare Federation, thus giving proper equity to the hospitals and justice to the community.

He is a reader with a retentive memory and so can quickly avail himself of the vast store of useful knowledge he has thus acquired. He is never dogmatic and though meticulous in his choice of words to develop an idea or an ideal, he also listens and is always willing and eager to accept correction or additional suggestions and added information.

He is a grand person with whom to work, always leading but also coöperating, so that all others feel they too are helpful and not just yes men. He is always direct in his approach to problems so that he, with Dr. Hawkes, fully deserves the affectionate appellation "Exemplar of integrity". This integrity has been demonstrated in his life work, in his home, in his friendships and in his devotion to our city and our country.

## PRESENTATION BY DR. ROYAL A. SCHAAF

It has been my great privilege to have been closely associated with Dr. Sprague, both professionally and personally, for more than a quarter of a century. As the result of this long association, my admiration and affection for him have become so great as to have exposed me at times to the just charge of violation of the First Commandment. I could tell you countless stories illustrative of his kindliness and generosity, his patience and persistence, his gentleness and unfailing good temper, his consideration for others, his intellectual honesty, his capacity for staunch friendship, his genius for organization and administration and the adoration of his patients. I will not dwell upon these, not because I would not greatly enjoy doing so but because I would only embarrass him. I have chosen rather to speak for the group of younger men, eleven in number, who have been his associates at the Presbyterian, St. James, City and Babies Hospitals, in which institutions we have served with him as our attending surgeon. Being the oldest, both in years and length of association, I feel qualified to speak for the group. Each one of us is devoted to him not only because of his exceptional professional competence, but also by reason of those sterling qualities of heart and mind which may be summed up in the word *Leadership*—including his surgical courage and daring, his composure in the face of the most harrowing emergencies, his apparently inexhaustible physical strength and mental energy, his resourcefulness, his superb technique and meticulous asepsis, his ability as a teacher and his willingness to share his vast knowledge, experience and skill with each of us, his consideration for the time, strength and convenience of his fellow workers, nurses as well as doctors, and his willingness to inconvenience himself at all times and in all circumstances either to further the welfare of our mutual patients or to assist one of us in surgical difficulties. He has that one indispensable requirement for leadership, the ability and willingness to do anything which he asks us to do and to do it better. No man of my acquaintance has received such loyalty from his asso-

ciates, not because he demands it but because he deserves it. What we think of him may be summed up by paraphrasing Antony's eulogy on Brutus:

"This is the noblest Roman of them all:
All the conspirators, save only he,
Did that they did in envy of great Caesar;
He only, in a general honest thought
And common good to all, made one of them.
His life is gentle, and the elements
So mix'd in him that Nature might stand up
And say to all the world 'This is a Man!'"

I am sure you wish to know what inscription has been engraved upon the plaque. The words are as follows:

Brilliant Surgeon, Resourceful Leader,
Humanitarian Citizen.

In my opinion the words are an understatement.

Edward — On behalf of the Council and Members of the Academy of Medicine, it is my happy privilege to present you with this award, which you so richly deserve—with it go our sincere admiration and deep affection.

## RESPONSE BY DR. EDWARD W. SPRAGUE

Mr. President and Friends:

Thank you, Royal, for the warm, friendly words you have just spoken in this presentation and thank you, Henry Barkhorn, for your loyal, kindly expressions of appreciation. Were I not ever mindful of the subject of the address to be given by my friend, Harrison Martland, "Oh Why Should the Spirit of Mortal Be Proud", which is to follow in a few minutes, I would be most proud.

I deeply appreciate the Edward J. Ill Award of the Academy of Medicine which you have given me tonight. The sentiments expressed on the plaque, which my family and I shall always treasure, seem to carry me into an unreal realm as if the words inscribed thereon could not really mean me. The Academy has bestowed this Award on Drs. Eagleton, Danzis, Hawkes, Bingham, Martland and Barkhorn, and it gives me pleasure that you have thought me worthy of being named to the ranks of such fine men. However, this recognition is for something far beyond my merits and efforts alone and whatever place I have in your minds and hearts has been due to the affection, loyalty, encouragement, sacrifice and inspiration of my family day after day and year after year. The loyal help of my associates led by you, Royal, and the endless hours of faithful services of associated officials, nurses and others in hospitals and elsewhere have assisted me through the years to breast the waves of circumstance. This community—the people, the hospitals, the profession, are close to my heart. The stirring interest and united efforts by our citizens of all creeds in meeting the civic and welfare needs of this area are always an inspiration. You who have gathered here tonight to participate in a time of happiness in my humble world, have my thanks and gratitude.

Opportunity was opened to me first in medicine in Newark when I was appointed an intern at the City Hospital, during which service Dr. Richard Connolly was most helpful to me as he was to all interns. Good fortune followed me after that pleasant full two-year service ended, when Dr. E. Z. Hawkes placed me as his assistant at St. James' Hospital and our close friendship has continued to this day. Later on Dr. Hugh Cook gave me my first surgical appointment at the City Hospital. After several years of hard work with his blessing, I was granted a surgical service at the City Hospital. Then I had the opportunity and good fortune to choose Royal Schaaf as my first associate, and one of my greatest joys today is to see my several associates in the City and other hospitals, all fine men, so competent and successful and loyal to each other. They promise much for the continued good quality of medical and surgical care in New Jersey.

The career of medicine, however humble, is a most inspiring field for interesting living. It gives great occasion for the intellectual life, at the same time boundless opportunities for the greatest good in human relationships—to be of service and to be a good citizen. It is true that there are hours of great distress and fatigue, flagging strength, helplessness and loneliness from which often painfully come needed discipline and wholesome humility. It is a privilege to be led by the guiding star of the ideal physician, an understanding, calm intelligence. Medicine is life upon the heights of destiny and, being of such usefulness to mankind, it follows that medicine carries with it inescapable responsibilities to society. It gives wide scope in which to strive to fulfill our mission, and a real mission we all have, even though it is not always clear to us at the time.

The great scientific accomplishments and attainments of the profession in the cure and prevention of disease have at last made the people, great and small, realize the efficacy of medical science. This state of progress, although far from our ultimate goal, brings added responsibilities and problems to the profession. The public, by and large, believes that

its medical needs, when occasion arises, will be met by the application of scientific medicine and the best medical care and, furthermore, rightfully believes that the physician is always ready to give aid to all who need his services. However, many in high places think that there is a serious flaw in the distribution of medical care due to economic or geographic circumstances and that physicians' services are not so available to all as they should be. Organized medicine is aware of the situation and the problem and is endeavoring to increase availability in every feasible manner, including spreading costs on a voluntary insurance basis whenever possible. Unfortunately, some individuals in our profession live in the realm of smug complacency and believe that the old methods of distribution in every situation will suffice, while on the other extreme, certain groups of the public and some powerful officials believe that only the State or the National Government can make medical service adequately available to all, and that such medical services should be on a compulsory basis.

"No man liveth unto himself", and the medical profession cannot live unto itself. It is an important part of society as a whole. Our place today is to be fully aware of the strong social forces of great emotional potentiality which are sweeping on with boundless momentum. Some of our people are persuaded, possibly as a result of political outlook or of an honest sense of frustration or economic insecurity, that whatever real or imaginary unfortunate status exists today is due solely to the shortcomings of the present system of free enterprise working in democracy, and there is evident danger that the great good of the system of private enterprise may be destroyed or seriously crippled and that would strike vitally at the roots of the present form of medical practice, which has carried us to this day of such low morbidity and longer life. To be sure, much remains to be done in both science and practice and particularly in distribution. One of the Proverbs says, "Where there is no vision the people perish", and we might add, where there is no vision the profession may perish. We might also quote an admonition from the Bible, "Physician, heal thyself".

No form of state, regimented, or mass production medicine can ever replace the primary vital factor of medical care—that is the function of the mind of the individual physician through the process of contemplation and cogitation whereby he alone, or with other minds, helped by apparatus and other aides diagnoses the condition and then outlines the orderly procedures of treatment along lines of knowledge with the wonderful hospital facilities and implementations and the care of expert, kindly nursing. It is true that accumulated scientific knowledge is essential and that all branches of the healing professions are essential but nothing can replace the simple operation of the mind of the physician. The physician functions to the best advantage to the patient in the interplay of free choice of physician in the atmosphere of the present patient-physician relationship, in the overall stimulating pattern of free enterprise. Compulsion must not be permitted here. Let us preserve the fundamental things in our national life and in medicine that are so essential to the best medical care for the patient. Let us arouse ourselves quickly to further develop plans and modes of distribution of this efficient medical care so as to make it available to everyone according to his needs. Let us urge coöperation of the proper authorities of town or state with the profession to provide jointly the same care to the less fortunate in the framework of free choice. Let us arouse the public to throw off the shackles of apathy, tragic ignorance, cults and dangerous self-medication and to seek advice from the physician.

To be alive today is a great privilege. There is a tremendous lure in living. Recently civilization has been endangered by the onslaught of the greatest malfactors since Earth began but the lights of culture and civilization will go on again. We all realize that life is full of heroism. This terrible war has shown us that time and again. The spirit of truth is still alive within us. The great moral force of justice is revealing its power in the minds of men who are to face the serious problems of today. If we become slaves to possessions, success or power, living will degenerate, but those dangers of life will always vanish before family, friendship, work, ideals, religion and faith in better things and better ways of being. The testing time is at hand for the individual, the profession and the nation, and while we may stumble as we have in war, the course will be slowly but finally upward and good human actions will continue to make good human nature. We need to give less thought to security and more to courage. This is a beautiful world and by our efforts alone we can make it more beautiful, more peaceful and a better place in which to live. Medicine is an important integral part of society. It is the duty of the profession to continue with increasing vision and good deeds to guide humanity with understanding leadership in the solution of the problems of life, health and happiness.

## NARCOTIC PRESCRIPTIONS

TREASURY DEPARTMENT
Bureau of Narcotics
New York 7, N. Y.
*Office of District Supervisor*
District No. 2
State of New York
and
*Fifth Collection District*
State of New Jersey

April 9, 1945

*To All Members of the Medical Profession in District No. 2:*

In November, 1940, I addressed a letter to you requesting your coöperation in preventing the improper and illegal distribution and use of all types of narcotic drugs. I want to extend my thanks to you for your assistance in the past, and once again to ask your coöperation in the situation which is now confronting us.

The extremely high cost of illicit drugs bought from the underworld and the extreme dilution of such drugs makes it very difficult for the criminal addict to satisfy his or her degenerate craving. The result is that such addicts are increasing their efforts to establish a source of supply among doctors and pharmacists, and to thus divert for their own loathsome use the drugs that are so badly needed by our armed forces and by our needful sick. Many of these criminal addicts are able to have the physicians prescribe in excessive amounts; or "raise" the amount placed on the prescription by the physician; or to secure prescriptions from several physicians, and through these means procure sufficient drugs to establish themselves as underworld dealers.

The improper and illegal prescribing of narcotic drugs to individuals merely to satisfy their addiction is a menace to our country and we must all work together to stop it finally and completely. Remember that an order for narcotic drugs written and issued merely for the gratification of drug addiction is not a "prescription" within the meaning of the Federal Narcotic Law and protects neither the physician who issues it nor the druggist who knowingly accepts and fills it. There may continue to be certain unscrupulous physicians who will overlook their responsibility in this matter. I warn you that it may become necessary to limit or completely stop the sale of narcotic drugs to such persons and to advise pharmacists to exercise extreme caution in filling prescriptions signed by such persons. In still other cases we will have to report the facts to the United States Attorney for prosecution in Federal Courts.

Do not write so-called narcotic prescriptions for narcotic drugs for general office use. The pharmacist is not authorized to fill such a "prescription". Narcotic drugs for direct dispensation in the course of professional practice should be obtained by the practitioner upon his official order form from a person or firm registered as a manufacturer of or wholesale dealer in narcotic drugs. Do not telephone a "prescription" for a patient to a druggist except in a case of extreme emergency and in such case be sure to furnish a properly written prescription at or before the time of delivery of the narcotic drug called for. The pharmacist may not legally sell or transfer narcotic drugs to a patient without receiving a proper prescription, and if he ignores this requirement, both he and the physician aiding and abetting the transaction may be liable to prosecution for the violation.

Let me remind you again of the methods used by common addicts to secure a prescription or drug from you, and permit me also to indicate to you how you may circumvent their evil designs.

1. *Simulating ailments that may or may not require narcotics. Addicts are peculiarly adept at this.*

Thoroughly examine patients, take x-rays, "test meals", and perform other proper scientific tests before prescribing narcotics regularly. Be extremely wary of patients who suggest that a certain narcotic is the only medication that will help them. Maximum use of non-habit-forming drugs as substitutes for narcotics.

2. *Stealing doctor's prescription blanks, writing their own "prescriptions" and forging a doctor's signature. Stealing medical bags.*

Do not keep your prescription pad on your desk or in sight of an addict. Do not leave your medical bag containing narcotics on the seat of your car, or in sight of an addict in your office.

3. *Presentation of letters from other physicians stating that patient is suffering from certain ailments; stating that they are traveling home or to a hospital and require a certain amount of drugs; showing an application from the U. S. Public Health Service Hospital, Lexington, Kentucky, and requesting narcotics until such time as they have to report to the hospital.*

Many of these letters are forgeries and it is incumbent upon the physician to determine for himself whether or not the person has a genuine medical need for narcotics.

In all cases of suspected irregularities, telephone or write the facts to the nearest office of the United States Bureau of Narcotics.

Garland H. Williams,
District Supervisor.

Headquarters Office:
253 Broadway, New York 7, N. Y. Rector 2-7273, Ext. 142.
Newark, N. J., Office:
858 Industrial Office Building, 1060 Broad Street, Newark 2, N. J. Market 3-5295.

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## GONOCOCCUS CULTURE STATIONS IN NEW JERSEY

In the February, 1943, issue of *The Journal* of The Medical Society of New Jersey there appeared an article entitled "Gonococcus Culture Facilities Offered to New Jersey Physicians". Below is a revised list of the culture stations which are coöperating with the State Health Department in providing this service.

Specimen tubes may be obtained at any of the following stations and must be delivered to the incubator at the station *within three hours* after the slant has been streaked. It is emphasized that to *obtain satisfactory results physicians must observe carefully the instructions which accompany each specimen tube.*

Allentown—Farmers Hospital
Asbury Park—Bureau of Health
Atlantic City—Atlantic City Hospital
J. S. Hunt Laboratory, 805 Atlantic Ave.
Kurland Pharmacy, 118 Dewey Pl.
Municipal Hospital
Bayonne—Bayonne Hospital
Belleville—Department of Health, Town Hall
Bloomfield—Health Department
Bridgeton—Bridgeton Hospital
Camden—Camden General Hospital, 5th & Linden Sts.
Cooper Hospital
West Jersey Homeopathic Hospital
Cape May Court House—County Court House
Cranford—Hampton Laboratory, 321 Casino Ave.
Dover—District Health Office, 16 W. Blackwell St.
East Orange—East Orange General Hospital
Health Department
Elizabeth—Elizabeth Biochemical Lab., 1137 E. Jersey St.
Health Department
Englewood—Englewood Hospital
Franklin—Franklin Hospital
Hackensack—District Health Off., Rm. 207 Administration Bldg.
Hoboken—St. Mary's Hospital
Irvington—Health Department
Jersey City—Christ Hospital
Hudson County Board of Health Lab.
Medical Center
Physicians and Surgeons Clinical Laboratory, 591 Summit Ave.
St. Francis Hospital
Kearny—West Hudson Hospital
Lakewood—Paul Kimball Hospital
Linden—Health Department, City Hall
Long Branch—Board of Health, City Hall
Monmouth Memorial Hospital
Mays Landing—District Regional Health Office
Millville—Millville Hospital
Montclair—Health Department, 65 Chestnut St.
Montclair Community Hospital
Mountainside Hospital
Morristown—All Souls' Hospital
Morristown Memorial Hospital
Mount Holly—Burlington County Hospital
Neptune—Fitkin Memorial Hospital
Neptune Twp. Board of Health
Newark—American Legion Hospital
Asen Clinical Lab., Medical Tower
Beth Israel Hospital
Coit Mem. Babies' Hospital
Columbus Hospital
Community Hospital
Newark Memorial Hospital
Presbyterian Hospital
St. Barnabas Hospital
St. James Hospital
St. Michael's Hospital
New Brunswick—Middlesex General Hospital
St. Peter's Hospital
New Monmouth—Middletown Health Center
Newton—Newton Memorial Hospital
Nutley—Department of Health, Municipal Bldg.
Ocean City—Friel Clinical Laboratory, 332 Asbury Ave.
Orange—Orange Memorial Hospital
Passaic—Beth Israel Hospital
Dr. Ogden's Clinical Laboratory, 20 Grove St.
Passaic General Hospital
Physicians Laboratory Service, 199 Monroe St.
Perth Amboy—Perth Amboy General Hospital
Phillipsburg—Warren Hospital
Pitman—District Health Office, 13½ S. Broadway
Princeton—Health Department
Princeton Hospital
Rahway—Rahway Hospital
Red Bank—Monmouth Clinical Lab., Rm. 28, Zobel Bldg., 157 Broad St.
Riverview Hospital
Riverside—Zurbrugg Hospital
Salem—Salem County Memorial Hospital
Secaucus—Hudson County Contagious Disease Hospital.
Somers Point—Shore Memorial Hospital
Somerville—Somerset Hospital

Summit—Health Department, 71 Summit St.
Overlook Hospital
Sussex—Alexander Linn Hospital
Trenton—McKinley Hospital
Mercer Hospital
St. Francis Hospital
Union City—Hudson Diagnostic Lab., 408 36th St.
Verona—Overbrook Hospital
Vineland—Newcomb Hospital
Weehawken—North Hudson Hospital
Westfield—Board of Health
West New York—General Research Laboratory, 444 W. 60th St.
Woodbury—Underwood Hospital

Note: If your community is not included in the above list and gonococcus culture facilities are not otherwise readily available, we suggest that you discuss the matter with your local health officer or communicate with the State Health Department.

A culture station must have a refrigerator and incubator which are accessible at all times.

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## NUTRITION IN EVERYDAY PRACTICE

S. WILLIAM KALB, M.D., Newark, N. J.
Nutrition Representative, Tuberculosis and Adult Disease Control Advisory Committee to the Subcommittee on Public Health

1. *Should less protein be eaten during hot weather?* The specific dynamic action of proteins raises the metabolism if there is a large amount of carbohydrate in the diet. In a diet containing a moderate amount of carbohydrates, the dynamic effect of proteins becomes less than the dynamic effect of carbohydrates and fats. Hence, the consumption of extra protein in the summertime will not cause an increase in the heating effect of the body.
2. *What is the best way to wash strawberries?* Bacilli salmonella typhi and bacilli coli are commonly found in strawberries. To eliminate these bacilli, wash the fruit in cold water and then immerse them in water kept at a boiling point for 15 to 30 seconds.
3. *Is there any other common vegetable besides tomato that is a good source for vitamin C?* Fresh potatoes are equivalent to tomatoes in this vitamin.
4. *What is the most easily digested milk?* Enzyme treated and hyper-heated milks digest relatively faster than pasteurized whole cow's milk.
5. *Of what value is vitamin D in rheumatoid arthritis?* Large doses of vitamin D are nil in this condition since there is no evidence that a vitamin D deficiency exists in arthritis. It is a mistake to use massive doses of vitamin D in chronic arthritis as it may cause toxic symptoms, possible renal damage, and gastro-intestinal upsets.
6. *How can one avoid the anemia and hypoproteinemia that usually follows pneumonia?* By the use of whole blood and plasma together with adequate amounts of protein in the diet.
7. *Is there a nutritional deficiency in patients who have poor post-operative wound healing?* A diet history taken on patients who appear for major surgery will elicite a poor vitamin C intake over a long period of time. The absorption of catgut sutures is usually delayed in vitamin C deficiency. Occasionally clean sutured wounds break down in spite of fine sterile technique at operation. In these cases there is evidence of a nutritional vitamin C deficiency affecting the proliferative powers of the cells. Many men feel that this vitamin should be administered routinely in the post-operative patient and in the treatment of injury.
8. *Is there any value in treating wounds with topical application of vitamins?* No value at all.
9. *Is riboflavin lost in milk by heating?* A small amount is destroyed by cooking but about 50 per cent of riboflavin in milk is lost from light. Hence, milk bottles should not be allowed to stand in the light outside the house after delivery.
10. *What foods have to be avoided in urolithiasis?* Foods high in oxalates should be avoided in the diet for this condition and also in the incipient stage of arthritis to prevent the formation of calcium oxalate crystals. These foods are:

| | | |
|---|---|---|
| Asparagus | Cocoa | Pepper |
| Beans | Coffee | Plums |
| Beets | Cranberries | Potatoes |
| Black tea | Endive | Rhubarb |
| Bread crust | Figs, dried | Sorrel |
| Chicory | Gooseberries | Spinach |
| Chocolate | Green beans | Strawberries |

## ASSOCIATION OF VENEREAL DISEASE CLINIC PHYSICIANS

A meeting of the Association of Venereal Disease Clinic Physicians was held on April 25, 1945, at 8:00 p. m. in the Executive Offices of the State Medical Society, with the president, Dr. R. Lewis McKiernan, presiding.

Those present were: Drs. Meyerson, Deitmaring, Osborn, McKelvie, Kohler, Melchior, Schenk, Filippone, G. H. Miller, Newburg, Saracino, Basralian, Axilrod, Parker, Durkee, Jenkins, Reiner, McCarroll and Usher.

Because of a full program reading of the minutes of the previous meeting and business was postponed.

Dr. Heller, Director of Venereal Diseases Division, U. S. P. H. S., addressed the group. He stated that there has been a tremendous increase in venereal disease rates in the European countries—as much as 100 per cent in occupied Norway. In 1943, the rate in the United States was the lowest in our history. The Selective Service data has been the most complete group of reported cases. The national figure was 47/1000; the lowest being in Minnesota with 4/1000, and in Florida up to 400/1000. The high rates are found in the southern and industrial areas. It is estimated that there are 3,300,000 cases of syphilis in the country at any one time.

The changes in the national viewpoint in Venereal Disease control are:

1. Realization of the necessity for an international stage of epidemiological control with close coöperation of adjoining countries.

2. Greater need for realistic education and community action.

3. Necessity for more realistic case finding. Emphasis entirely on case finding.

4. The factor of the "immature" personality in those who develop Venereal Diseases.

The latest developments in penicillin therapy and expectation of great increase in Venereal Disease rate after the war were discussed.

Dr. P. S. Pelouze, Assistant Professor of Urology, University of Pennsylvania, spoke on gonorrhea rates and the failure of sulfa to maintain therapeutic efficiency. The pathology of gonorrhea in male and female was discussed and the best diagnostic procedure taken up.

Dr. Markowitz reported that the Constitution and By-Laws had not yet been established and will be presented at a later meeting.

The Nominating Committee, consisting of Drs. Axilrod, Markowitz and Pincus, submitted the following nominations, which were acted on by the Association, and duly elected:

President—Dr. R. Lewis McKiernan
Vice-President—Dr. Maurice H. Axilrod
Secretary—Dr. Isidore Pincus
Treasurer—Dr. Francis A. Deitmaring.

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## SUPPLEMENTARY LIST OF MEMBERS No. 1

The figures in parentheses refer to County Societies as follows: (1) Atlantic, (2) Bergen, (3) Burlington, (4) Camden, (5) Cape May, (6) Cumberland, (7) Essex, (8) Gloucester, (9) Hudson, (10) Hunterdon, (11) Mercer, (12) Middlesex, (13) Monmouth, (14) Morris, (15) Ocean, (16) Passaic, (17) Salem, (18) Somerset, (19) Sussex, (20) Union, (21) Warren.

Abramo, Anthony E., 141 Glen av., Midland Park (2)
Adler, Fritz F., 162 Trenton av., Paterson (16)
Amato, Charles P., 424 Broadway, Camden (4)
Anderson, Ethelyn, 195 Euclid av., Ridgef'd Park (2)
Basralian, Jos. B., 333 Wash'gton pl., Hasb'kHts.(2)
Brock, H. F., 417 W. Broad st., Westfield (20)
Carlin, Edward J. M., 1423 Irving st., Rahway (20)
Ciampa, Ralph, 383 Bath av., Long Branch (13)
Cooperman, William, 647 Market st., Newark (7)
Costabile, Vincent, 324 2d av., Lyndhurst (2)
Cronk, E. Irving, 57 Livingston av., NewBr'sw'k(12)
Dalberg, Walter, 500 Cherry st., Elizabeth (20)
Deehl, Seymour R., 1026 E. Jersey st., Elizabeth (20)
Dolganos, Moses, 268 Palisade av., Jersey City (9)
Duffy, Joseph F., 358 Kinderkamack rd.,Westw'd (2)
Figliolino, Francis, 272 W. Milton av., Rahway (20)
Fechner, Fred., 846 Garrison av., Teaneck (2)
Fechner, Herta, 846 Garrison av., Teaneck (2)
French, Harry J., 28 Franklin av., Merchantville (4)
Friedman, Edna Charney, 584 Br'dway,Paterson(16)
Garibaldi, Louis J., 1016 Hudson st., Hoboken (9)
Goldberg, Jacob, 155 Franklin av., Long Branch (13)
Guidice, Vincent W., Harrison av., Waldwick (2)
Haskin, Aaron H., 22 Goldsmith av., Newark (7)
Hill, Clarence T., 116 E. Hazelwood av., Rahway (20)
Hill, John A., 511 Cedar av., Allenhurst (13)
Hilton, Carence O., 556 N. 7th st., Newark (7)
Hoops, Harold J., 20 Woodland Park dr., Tenafly (2)
Hubbard, S. T., 241 Main st., Hackensack (2)
Jarecki, Max, 527 Bangs av., Asbury Park (13)
Jones, Lewis H., 139 Grant av., E., Roselle Park (20)
Jordan, Alexander D., 238 E. Main st., Manasq'n (13)
Jordan, Walter L., 145 Engle st., Englewood (2)
Kaplan, Isaac, 901 Garrison av., Teaneck (2)
Kaufman, Edgar W., 2225 River av., Camden (4)
Keller, Rudolph J., 821 Garden st., Hoboken (9)

Kelley, Charles B. P., 336 Engle st., Tenafly (2)
Kingsma, John G., Goffle Hill rd., Wyckoff (2)
Klapper, L. L., 421 W. 7th st., Plainfield (20)
Krohn, Mark, Campbell av., Belford (13)
Lefkowitz, Jacob H., 445 64th st., West New York(9)
Lehman, Irving J., 31 Lincoln Park, Newark (7)
Levine, David B., 647 Broadway, Paterson (16)
Lewis, Alexander, 1554 Irving st., Rahway (20)
Lovejoy, James L., 224 Somerset st., B'd Brook (18)
Lovett, Irving K., 110 E. Front st., Red Bank (13)
Luca, Frank, Westwood av., Long Branch (13)
Luca, Mildred, Westwood av., Long Branch (13)
Lueddecke, Roland E.,216 Randolph av.,E.Rthrfd.(2)
Mangone, George F., 811 Palisade av., Union City(9)
Margolin, Samuel J., 1012 80th st., North Bergen (9)
Metzger, Karl F., 401 5th av., Belmar (13)
Mohr, Frank L., 560 Morris av., Summit (20)
Neumann, Alfred, 432 Washington av., Linden (20)
Norwich, Louis E., 355 Ave. C, Bayonne (9)
O'Gorman, Michael W., 46 Mercer st., Jersey City (9)
Opfermann, John L., 167 Bay av., Highlands (13)
Padney, Edward V., 452 Jersey av., Jersey City (9)
Placa, James A., 200 Oak st., Ridgewood (2)
Richardson, Arthur H., 60 Orange rd., Montclair (7)
Rigeron, D. George, 160 Willard av., Bloomfield (7)
Rowohlt, George O., 160 E. Madison av., Dumont(2)
Saco, Louis S., 922 Main st., Paterson (16)
Santor, G. Frank, 3176 Westfield av., Camden (4)
Scala, H. Albert, 41 Madison av., Jersey City (9)
Schenker, Sarah S., 635 Garden st., Hoboken (9)
Schoonover, Richard, 459 Park av., Paterson (16)
Schurman, Emil W., 710 Ocean av., Jersey City (9)
Scott, Harold R., 68 Central av., Orange (7)
Silverman, Theodore M., 105 Elmora av.,Elizab'h(20)
Silverstein, Max, 605 1st av., Asbury Park (13)
Smith, A. L. Marshall, 62Bayard st.,NewBrnswk.(12)
Spence, Henry, 2540 Boulevard, Jersey City (9)
Stokes, James S., 32 Main st., Little Falls (16)
Straus, Frederick W., 2708 Westfield av., Camden(4)
Tannert, Carl H., 331 77th st., No. Bergen (9)
Taylor, Harold W., 247 Mountain rd., Englewood (2)
Timlin, J. W., 64 Beech st., Arlington (9)
Vaccaro, Sebastian P., 509 4th av., Asbury Park (13)
Vann, Dorothea, 63 Spring lane, Englewood (2)
Wechsler, Joseph, 3342 Boulevard, Jersey City (9)
Weigert, Wolfgang U., 266 Marlton av., Camden (4)
Whitcher, Burr, 214 High st., Mt. Holly (3)
Willey, Harry, 47 E. Front st., Red Bank (13)
Yarnell, Helen, 111 E. Front st., Plainfield (20)
Yood, Raphael, 401 Grant av., Plainfield (20)
Zeitlin, Herman H., 943 N. Wood av., Linden (20)

## WITH NEW JERSEY MEDICAL AUTHORS

Compiled by MILDRED V. NAYLOR, Librarian, Academy of Medicine of Northern New Jersey

It is requested that any New Jersey physician who publishes an article outside the state, notify the Editorial Office in Trenton, giving the title of the paper and the name of the periodical, as well as the month, date, volume and page number. It would also be helpful to this office if members would notify us of articles published by their colleagues.

BAKER, ELSWORTH F.—Marlboro
Report of analysis in conjunction with convulsive therapy. Psychiatric Quart. 19:71-89, Jan. '45

CARPENTER, CEDRIC C. (with Paul L. Gorsuch)—Summit (in service)
Bacterids provoked by internal sulfonamide administration. U. S. Nav. M. Bull. 44: 681-685, Apr. '45

CORBUSIER, HAROLD D.—Plainfield
Conservation of manpower for war. J. Internat. Coll. Surg. 7: 108-115, Mar.-Apr. '44

CRUTCHFIELD, W. E., JR., Ph.B. of Med.—Rahway (Merck & Co.)
Improvement in nutrition as protection against industrial toxicity. Indust. Med. 14: 324-330, Apr. '45

DIEFFENBACH, RICHARD H.—Newark
Acute putrid lung abscess based on a series of 106 consecutive personal cases. Clinics 3: 1392-1407, Feb. '45

FOSTER, JACKSON W., and KAROW, EDWARD O.—Rahway (Merck & Co.)
Microbiological aspects of penicillin. VIII. Penicillin from different fungi. J. Bact. 49: 19-29, Jan. '45

FOSTER, JACKSON W.—see also Woodruff, H. Boyd

GOLDBERG, DAVID—Westwood (in service)
Joint aspiration; a simple method. Am. J. Surg. 68: 89-90, Apr. '45

GOLDSTEIN, HYMAN I.—Camden

1. Ulcer of the stomach and duodenum. Medical Way 7: 3-5, Mar. '45

2. Relation of the anemias to gastro-intestinal disease and disturbances of the nervous system. Medical Way 7: 3-5, Apr. '45

GORDON, MAURICE B.—Ventnor
Medicine in colonial New Jersey and adjacent areas. Bull. Hist. Med. 17: 38-60, Jan. '45

Hahn, William H.—Newark
Rôle of vitamins in the physiology of vision. J. Med. Soc. New Jersey 42: 81-88, Mar. '45

Hatch, Harold S., and Probst, E. W. (in service)—Morristown
Effects of tetryl on the lungs. Indust. Med. 14: 189-190, Mar. '45

Jones, Helen; Rake, Geoffrey, and Stearns, Barbara—New Brunswick (Squibb Institute for Medical Research)
Studies on lymphogranuloma venereum. III. Action of the sulfonamides on the agent of lymphogranuloma venereum. J. Infect. Dis. 76: 55-69, Jan.-Feb. '45

Karow, W.—see Foster, Jackson, W.

Kern, E. Clarence—Montclair
Simplified local treatment of sinusitis with sodium sulfathiazole. J. Med. Soc. New Jersey 42: 89-90, Mar. '45

Klompus, Irving—Bound Brook (in service)
Fractures of toes; a simple method of treatment. U. S. Nav. Med. Bull. 44: 850-851, Apr. '45

Norton, James F.—Jersey City
Mortality study of 187 deaths in 66,376 live births. Am. J. Obst. & Gynec. 49: 554-566, Apr. '45

Probst, E. W.—see Hatch, Harold S.

Rake, Geoffrey—see Jones, Helen, et al.

Rigeron, D. G.—Belleville (Walter Kidde Co.)
Industrial rehabilitation of the handicapped. Indust. Med. 14: 173-177, Mar. '45

Segard, C. P.—Leonia (with others)
Prevention of hemorrhagic anemia after blood donation in normal adults. New York State J. Med. 45: 394-396, Feb. 15, '45

Stearns, Barbara—see Jones, Helen, et al.

Stein, Russell—see Usher, Glenn S.

Usher, Glenn S., and Stein, Russell—Trenton
State-wide gonococcus culture service; a system of utilizing the mail for transmission of specimens. Ven. Dis. Inform. 26: 77-80, Apr. '45

Woodruff, H. Boyd, and Foster, Jackson W.—Rahway (Merck & Co.)
Microbiological aspects of penicillin. VII. Bacterial penicillinase. J. Bact. 49: 7-17, Jan. '45

## OBITUARIES

### DR. THEOPHILUS H. BOYSEN

Dr. Theophilus H. Boysen of Egg Harbor, who was president of the Atlantic County Medical Society in 1943-1944, died at Jefferson Hospital on March 31, 1945.

Dr. Boysen, who was born in 1881, was graduated in 1901 from the Philadelphia College of Pharmacy and then entered Jefferson Medical College, receiving his M.D. degree in 1905. Upon completion of his education he took over the practice of his father in Egg Harbor. In those days it was customary to operate a pharmacy in connection with the practice of medicine and for many years he continued to manage Boysen's Pharmacy.

Dr. Boysen was active in health and civic affairs in Egg Harbor, having served as medical examiner in the public schools, as a member of the Board of Health and, at one time, as councilman.

Dr. Boysen was a member of the Atlantic County Medical Society, The Medical Society of New Jersey and the American Medical Association.

### DR. EARLE B. STOKES

Dr. Earle B. Stokes of South Orange, died on April 29, 1945, in Orange Memorial Hospital of a heart attack while playing golf at the Essex County Country Club.

Dr. Stokes was born in Freehold in 1892 and was graduated from Jefferson Medical College in 1914. During World War I he served in the Army Medical Corps overseas. He began practice in East Orange and in 1926 started specializing in urology. He was attending surgeon at Orange Memorial Hospital and consultant urologist at East Orange General, Dover General and several other hospitals.

Dr. Stokes was vice-president of the New York Urological Society, a fellow of the American College of Surgeons, member of the New Jersey Society of Surgeons, Orange Mountain Medical Society, National Urological Society, Essex County Medical Society, The Medical Society of New Jersey and the American Medical Association.

### DR. ROBERT G. STONE

Dr. Robert G. Stone, former medical director of the Trenton State Hospital, died on April 27, 1945, at a private hospital in Atlanta, Ga. He had been seriously ill for more than a week as a result of a severe heart attack and pneumonia.

Dr. Stone was born in Georgia in 1881, and was graduated from the University of Georgia School of Medicine in 1906. He was a country doctor until he decided to enter institutional work. He came to the Trenton State Hospital in 1919 and for many years was clinical director and assistant to the late Dr. Henry A. Cotton, whom he succeeded as medical director in 1930. Because of a heart condition Dr. Stone retired as medical director on May 1, 1944, when he was succeeded by Dr. J. B. Spradley. Following his retirement, he returned to his native Georgia.

Dr. Stone was actively identified with many Trenton organizations. He was a member of the Mercer County Medical Society, The Medical Society of New Jersey, American Medical Association, Sons of the American Revolution and the Society of Colonial Wars.

# COUNTY SOCIETY REPORTS

## ATLANTIC COUNTY

Walter B. Stewart, M.D., Reporter

The regular monthly meeting of the *Atlantic County Medical Society* was held Friday, April 13, 1945, at the Hotel Chelsea, with the President, DR. CHARLES HYMAN, presiding.

The speaker of the evening was DR. W. EMORY BURNETT, Professor of Clinical Surgery, Temple University Hospital, whose subject was "Recognition and Surgical Management of Gastric Lesions". Although many complaints and minor dysfunctions in adults are referable to the stomach, actual diseases of the stomach and duodenum can be classified into a few major lesions, such as peptic ulcer, carcinoma, benign tumors, syphilis, duodenal diverticula, duodenal obstruction; and into a few symptom complexes, such as gastritis, pyloric spasm and psychosomatic factors. Dr. Burnett illustrated his talk with a series of lantern slides. Accurate diagnosis is the basis of successful treatment. Most general practitioners have adopted practical methods of screening out the most vague symptoms by therapeutic tests. This method may be dangerous unless carefully done and repeatedly checked, since early carcinomatous symptoms are vague, and since the presence of psychic friction not only fails to exclude organic disease but actually may produce ulcer, encouraging the two most potent etiologic factors, excessive secretion of acid and overactivity of pylorus.

In general, all adults with gastric symptoms should be carefully analyzed as to history and physical examination for leads toward the offending lesion. Laboratory aids should be used to prove or disprove each suspicion, unless extremely vague or transient. Only when organic disease is excluded by thorough study is it safe to assume that malfunction is caused by psychic factors, allergy, dietary indiscretions, poor physical hygiene or disturbed endocrines.

The following facts concerning ulcer are of value: (1) Age. Most cases occur between twenty and thirty, a moderate number between thirty and forty, but a few up to sixty years, which is unfortunate since it may be confused with carcinoma. (2) Periodicity. (3) Cycle—time slide an outstanding symptom. (4) Frequency of hemorrhage. (5) Necessity of gastric analysis. (6) X-ray—however, spasm from other causes may mislead. (7) Gastroscopy—increasing use is justified. (8) Differential between ulcer and carcinoma. Age overlap may confuse. Carcinoma should be suspected when ulcer fails to heal in three or four weeks of ideal management.

The only curative treatment is excision by gastrectomy. Operability is still low, 45 to 50 per cent. Mortality for carcinoma resection cases is about 10 per cent. Worthwhile palliation can be accomplished in many cases. Twenty per cent are alive and well three years after operation, or 50 per cent of those without glandular extension. In the preparation of patients for resection, one must first treat any anemia, dehydration or undernutrition, especially using proteins and ascorbic acid. In obstruction, use emesis, lavage and drainage, which can be combined with drip feedings of reinforced liquids. Loss of irritation and edema improves comfort and promotes passage of nourishment.

Post-operative care is important. Routinely we use gastric suction which deflates the stomach, indicates function of stoma and prevents back pressure on duodenal stump. After twenty-four hours, clamp for three hours, measure quantity and drain for twenty minutes; measure and remove tube as soon as gradient is downward; keep watch on blood and protein. Most patients are on a soft diet by the fourth or fifth day. In ulcer cases there must be restriction of diet for a few months and elimination of smoking and alcohol. Out of bed in six or eight days; discharged in ten or twelve days.

The following are the indications for operation in peptic ulcer: (1) Intractability—or when economic conditions or poor discipline on part of patient warrants it. (2) Perforation. (3) Hemorrhage —Operate after second attack if a proven ulcer; after one attack if a chronic perforation. Operate during first attack if a proven ulcer and the patient is over fifty and bleeding lasts more than forty-eight hours. Huge transfusion and gastrectomy work well if done early.

Benign tumors of stomach are rare, and are usually not discovered unless there is bleeding or obstruction. Remove by local excision.

Syphilis of stomach produces few symptoms. Suspect extensive x-ray findings in a young person. There is prompt response to antiluetic therapy.

Duodenal diverticula should be left alone unless they are too close to the common duct, in which case they can be resected or inverted.

## BERGEN COUNTY

H. E. Reinhold, M.D., Reporter

The regular meeting of the *Bergen County Medical Society* was held at Bergen Pines Hospital, Oradell, on the evening of April 10, 1945, and was called to order by the President, DR. WILLIAM K. HARRYMAN, at 9:30 p. m.

DR. KEIR announced that April was Cancer Month and that the Cancer Association had initiated a drive to collect $400,000 for the State of New Jersey, of which $35,000 was allotted to Bergen County. He reiterated briefly the rôle of the organization and asked that the medical profession support it.

The speaker of the evening was IRVING R. ROTH, M.D., Associate Attending Cardiologist, Mt. Sinai Hospital, New York, who spoke on "Cardiac Arrythmias". Dr. Roth classified arrythmias into four groups: (1) those originating at the S.A. node; (2) those caused by irregularities of transmission to the A. V. node; (3) those caused by ectopic impulses arising from other pacemakers; (4) those caused by impulses emanating from the circular

bands of muscle around the great vessels of the heart, often known as circus rhythm. The speaker clearly described the various clinical evidence of these abnormalities and discussed their treatment in detail.

The paper was discussed by Drs. Ringwald and Black. Many questions were asked from the floor and cheerfully answered.

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The regular meeting of the *Bergen County Medical Society* was held at Bergen Pines Hospital, Oradell, on May 8, 1945, and was called to order by the President, Dr. William K. Harryman, at 9:30 p. m.

The report of the Nominating Committee was read and the following officers and delegates were elected:

President, Frederick G. Dilger
Vice-President, Albert W. Cloud
Treasurer, Frederick L. Muller
Reporter, Herbert E. Reinhold
Secretary, Rudolph C. Schretzmann

Delegate to State Nominating Committee: H. B. Wilson

Alternate: C. A. King

Delegates to House of Delegates — 1945-1947: Joseph R. Morrow, Arcangelo Liva, William L. Vroom, George M. Knowles, G. Barton Barlow, Victor A. Blenkle

Alternates: Louis A. Hitzmann, Lyman Burnham, William C. Rucker, Norman Myers, John S. Decker, Henry R. Balze

The speaker of the evening was John Dietrich, M.D., Associate Professor of Medicine, Cornell University Medical College, New York, who spoke on "The Indications and Therapeutic Applications of Penicillin."

Dr. Dietrich discussed the various modes of administration in detail and included the intramuscular, intravenous, intrathecal, local and oral routes. It was pointed out that the oral dose should be about five or six times the intramuscular dose in order to assure the proper blood level of the preparation. The drug is easily tolerated and in pneumonia at least 50,000 units should be administered every two hours in capsule form. Since the drug is rapidly excreted in the urine in about three hours, methods to prolong its action have been sought. It is found that if the drug is mixed with peanut oil and beeswax and given intramuscularly blood levels are retained for six hours. Single, large intramuscular doses of 50,000 units or more can be given and the absorption can be prolonged if an icebag is applied to the site of injection for 15 minutes before the injection is made and then again after the drug has been administered.

The speaker also explained the use of penicillin in ointments for topical application.

Many questions were answered from the floor and the meeting adjourned to collation at 11:25 p. m.

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## BURLINGTON COUNTY

T. B. Dickson, M.D., Reporter

The *Burlington County Medical Society* held its monthly meeting at the Riverton Country Club on April 12, 1945.

The guest speaker was Captain John R. Neese of the United States Army, who is attached to the University of Pennsylvania. Captain Neese discussed infectious hepatitis and serum hepatitis. He told of the difficulty in distinguishing between the two, the methods used, and their treatment. It was a very interesting talk on a subject about which more is being learned daily.

Dr. Peacock, Secretary of the Society, announced that all of the members have paid their dues for the current year.

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## CAMDEN COUNTY

Joseph C. Lovett, M.D., Reporter

The monthly meeting of the *Camden County Medical Society* was held at the Camden City Dispensary on April 3, 1945, with Dr. Henry Decker presiding. Thirty members attended.

The guest speaker of the evening was Dr. Harry L. Rogers, who spoke on "Allergy". The general practitioner, especially the pediatrician, sees the allergic patient first. All conditions of allergy are due to hypersensitiveness. A second or subsequent exposure to the allergin produces the allergy. Inheritance plays an important part and twice as much is transmitted through the female. Heredity plays no rôle in anaphylaxis. There are probably 1,000,000 asthmatics in the United States. Two to three per cent of the population have hay fever and 85 per cent are susceptible to ivy poisoning.

Allergy involves different groups:

1. Atopic group
   a. Asthma
   b. Hay fever and allergic parents
   c. Atopic dermatitis
2. Hypersensitive to infection including serum disease and drug allergy.
2. Contact dermatitis.
4. Group containing no allergins as angioneurotic edema and urticaria
5. Physical allergy

The criteria for allergic diseases is the presence of eosinophilia, response to tests, history of heredity, and clinical response to exposure to the allergin. Allergy is a self limited disease. The average course is, the patient gets worse the first seven years, levels off and gradually clears up. It is very essential that the patient coöperate with the physician.

The skin test is the best method. The scratch test is not a good method as it is very inaccurate. The intradermal is better. There is very little danger with this test if a careful history is taken. Asthma is the most difficult to treat. Heredity and the intrinsic and extrinsic factors enter into it. Molds and fungi add to the difficulty.

Treatment must eliminate the offending substance. If this cannot be done, then we must change the sensitization. Change of climate does not help. Patients may even be worse with this change. Adrenalin should not be given in oil as the patient may be allergic to the oil. Hepamine has been worthless in Dr. Rogers' experience. Ultra-violet ray treatment of the blood may show a severe reaction. Intravenous glucose and also

aspirin help. Morphine should not be used. It is best not to give pollen injections at two-week intervals during the year, as during the height of the pollen season the patient will be getting large doses. In contact dermatitis, it is often very difficult to find the cause. Vitamin "C" has been disappointing. Aminophyllin is a valuable drug in the treatment of asthma but also a dangerous one.

The paper was discussed by Drs. Kline, Shipman, Clark and Pratt. In closing the discussion, Dr. Rogers stated that fatigue plays a big rôle and causes flare-ups of the allergy. Cosmetics are also great offenders. Vernal conjunctivitis is usually seen in males. It is not caused by pollen or molds. Endocrine glands definitely tie up with allergy. Food allergies do change; the offending food can be tolerated at times and at another time cause trouble. Soap is an important offender. Human dander can cause eczema.

Dr. Shipman reported on the Insurance Program. He stated that we still need more members to sign to make up the required percentage to get the Insurance. All those who had not signed were urged to do so.

A committee was appointed composed of Dr. Shipman and Dr. Pratt to determine who was eligible to get a certificate for fifty years in practice.

## CAPE MAY COUNTY

C. W. Way, M.D., Reporter

The Annual Meeting of the *Cape May County Medical Society* was held at Maier's Sea Food Restaurant, Ocean City, at 9:00 p.m., May 8, 1945.

Results of the annual election were as follows:

President, Dr. George M. Brooks, Cape May Court House

Vice-President, Dr. J. S. D. Eisenhower, Wildwood

Secretary and Reporter, Dr. C. W. Way, Sea Isle City

Treasurer, Dr. Frank Hughes, Cape May City

Nominating Delegate, Dr. C. W. Way

Delegates to State Convention: Dr. George F. Dandois, Dr. Herschel Pettit, Dr. C. W. Way.

Board of Censors: Dr. Aldrich Crowe, Dr. George F. Dandois, Dr. Frank Hughes

The reorganization of the Woman's Auxiliary was discussed and it is hoped that definite action will be taken in the near future.

A very fine lobster supper was served at 11:00 p.m.

## CUMBERLAND COUNTY

Norman W. Henry, M.D., Reporter

The April meeting of the *Cumberland County Medical Society* was held in Millville at the Trinity Social Hall on April 10, 1945. Dr. Mary Bacon, President, presided.

Dr. Charles E. Sharp of Port Norris, N. J., recommended that a political committee be appointed to wait on a Steering Committe of Cumberland County. The purpose of this committee is to seek coöperation between the medical profession and the county officials in matters pertaining to public health.

Dr. Albert B. Kump of Bridgeton made a report of the Welfare Committee meeting.

Election of officers took place and the following were selected for 1945-46:

Dr. George N. Thomas, Vineland, President

Dr. Albert B. Kump, Bridgeton, Vice-President

Dr. F. Muriel Ramsey, Millville, Secretary

Dr. H. H. Wilson, Bridgeton, Treasurer

Dr. Norman Henry, Vineland, Reporter

Dr. Charles M. Gray, Vineland, Censor

Those elected to the Executive Board were: Dr. Edward J. Thalheimer of Vineland, Dr. E. C. Lyons, Bridgeton, and Dr. S. L. Siegel of Millville.

Dr. Stanford Mulholland, Professor of Urology at the Women's Medical College of Philadelphia, Pa., addressed the group on the subject "Blood in the Urine—Its Significance", stressing the importance of history, clinical and x-ray studies, diagnosis and treatment, with lantern slide presentation of cases.

He discussed each case as a representative of patients which could be classified under the following pathological conditions: tumor, calculi, obstruction, inflammation, pappilitis, and allergy.

His interesting, comprehensive discussion was closed with a brief outline on therapy. Sulfonamides, azo dyes, neoarsphenamine and penicillin and their individual merits in therapy are all important. In the resistant type infection cases, combination of the above drugs are more successful if administered not too closely. Penicillin is more successful on sulfa-resistant infections than if used primarily.

A dinner was served following the adjournment of the meeting.

## GLOUCESTER COUNTY

A. Guy Campo, M.D., Reporter

The *Gloucester County Medical Society* met on March 15, 1945, 9:00 p.m., at the Court House in Woodbury. Dr. William G. Harris presided.

Health and accident insurance, relative to our society, was discussed.

Dr. William W. Pedrick reported that Dr. Scott is requesting, for the second time, completed forms of all civilian M.D.'s practicing in Gloucester County. The Secretary has the data.

The Treasurer was instructed to give Dr. Pedrick two dollars to give to the Court House janitor.

Dr. Diverty was appointed to find a new meeting place for the April meeting.

The speaker of the evening, Dr. Edmund C. Hessert, Professor of Gynecology, Hahnemann Medical School, was introduced by Dr. A. G. Campo. Dr. Hessert spoke on "Abnormal Vaginal Discharges". Vaginal bleeding and pain are the primary reasons patients consult gynecologists, while abnormal vaginal discharges were third in order.

Types of vaginal discharge:

1. Pathological
2. Physiological

Degrees of discharge:

1. Profuse
2. Moderate
3. Scanty

Physiological discharges:

1. With menses—pre and post-menstrual. No treatment.
2. With ovulation—scant in mid-period due to mucous glands of cervix.
3. With sexual excitement
4. With pregnancy
5. With puerperium
6. Unexplained discharge with no reason and after pathology cannot be found
7. With fatigue, exhaustion, etc.—due to systemic reasons
8. With nervousness

Pathological discharges due to disease of female organs:

1. Vaginitis; found in children, in gonorrhea, in ovarian extrogenic hormone change in changing and senile women. Causes:
   a. Gonorrhea
   b. Tuberculosis
   c. Non-specific
   d. Syphilis
   e. Erosion, eversion, etc.
   f. Trichomonas protozoa
      Treatment—Allantoinal ointment morning and evening; douche with lactic acid right through menses for at least three full months.
   g. Fungus type infection, with pregnancy and diabetes—use gentian violet.
   h. Burns
   i. Foreign bodies
   j. Trauma
   k. Tumors—polyps, carcinoma, etc.

The following members were present: Drs. Diverty, Rogers, Livengood and Underwood of Woodbury; Dr. Ulmer, Gibbstown; Drs. Sinexon and Di Marino, Paulsboro; Drs. Patterson and Campo, Westville; Dr. Footer, Williamstown; Dr. Pedrick, Glassboro; Dr. Harris, Mullica Hill.

## HUDSON COUNTY

H. J. Perlberg, M.D., Reporter

A regular meeting of the *Hudson County Medical Society* was held on April 3, 1945, at the Masonic Club, Jersey City. The meeting was called to order by the President, Dr. Walter D. Weber, at 9:40 p. m. It was regularly moved, seconded and carried that the minutes of the regular and Executive Committee meetings be approved as printed in the April Bulletin.

The following were elected to membership: Drs. Abraham Geffner and Harry Hershey of Union City and Sarah S. Schenker of Hoboken.

Dr. George Clinton Andrews, Attending Dermatologist, Presbyterian and Roosevelt Hospitals, New York City, spoke on "Recent Advances in Dermatology".

Dr. Andrews presented his subject as follows:

1. Penicillin in the treatment of syphilis.
2. Penicillin and sulfa drugs in other dermatological conditions.
3. Penicillin ointment.
4. Some familiar skin eruptions; their cause and management.
5. Ringworm of the scalp and cable-rash (by request).

1. In discussing penicillin treatment of syphilis, Dr. Andrews stated that early hopes of rapid cure have not materialized. There have been many serological and muco-cutaneous relapses. While immediate results in some cases were sufficiently spectacular to cause a spontaneous outburst of enthusiasm in which the new drug was hailed as *the* cure for syphilis, further investigation and follow-up has unfortunately found penicillin therapy insufficient to effect *permanent* cure of this disease in a high percentage of cases.

It is true, however, that penicillin is still considered the most important drug in the treatment of early syphilis. Its use causes syphilitic skin lesions to disappear promptly. The Wassermann reaction following penicillin therapy fluctuates for several months before it becomes negative. After being negative for a few months, it may revert to positive. If reaction does return to positive, a second course of penicillin treatment is justified. Subcutaneous injection is the method of choice. The use of this substance involves no dangers.

The effective dose of penicillin for the treatment of early syphilis is 40,000 units every three hours for sixty injections, making a total dose of 2,400,000 units in eight days. Injections should be given at regular intervals, both day and night.

The effectiveness of penicillin in combination with other drugs was discussed—mapharsen and neoarsphenamine, for example. Dr. Andrews warned that massive doses of arsenicals are hazardous, and that patients should be hospitalized and observed closely during such a course of treatment.

2. Staphylococcic and streptococcic infections were discussed as being amenable to penicillin therapy. Anthrax, also, was named as responding splendidly to this substance.

Both penicillin and the sulfa drugs when used judiciously are proving of great value in the treatment of acne, frequently replacing the x-ray therapy formerly employed. An obstinate case of exceptionally severe and disfiguring pustular acne in a young man was described as having responded amazingly well to sulfadiazine. The condition cleared up completely in five days using two grams daily of sulfadiazine. Following the use of sulfa drugs, recurrence is unlikely. *All* cases of acne do not react satisfactorily to the sulfa drug. In the treatment of pemphigus, neither penicillin nor the sulfa drugs are of value.

3. The therapeutic value of penicillin ointment was described as excellent, despite an occasional tendency to sensitization to it. It was highly recommended in the treatment of furuncles, carbuncles, sycosis vulgaris, and most cases of acne and impetigo, the latter frequently being cleared up completely in two or three days. It is useful in the mouth in Vincent's angina, and on the cervix in endocervicitis.

In making this ointment, not as yet procurable in prepared form, it is worthy of note that penicillin seems to deteriorate more rapidly in aqueous solution. It should be dissolved in propylene glycol or diethylene glycol, or mixed in mineral oil using

a base such as a mixture of lanolin and petrolatum as a vehicle. It shows a tendency to deteriorate if not kept under refrigeration, although in ordinary room temperature it has been known to lose very little of its original potency over a period of three months. This ointment, of course, is for local use only.

4. In females, children and adults, swelling of the eyelids, of the lips, or of the face in general, with rash and itching of the parts involved, is due in a surprising number of instances to the use of nail polish. Cure will not be accomplished by changing to another brand of polish; the practice of using nail polish must be discontinued.

A lesion similar in appearance to the above, also with swelling and itching, and frequently involving the hands as well as the face, may be due to feather sensitivity, and usually develops after the individual has been using the same feather pillow over a long period of time.

In like manner, artificial tortoise shell, a plastic compound used for the rims of spectacles, is responsible for many an eruption on the bridge of the nose and wherever the material contacts the skin. Certain metal rims irritate similarly. The wearing of a nickel wrist-watch, the handling of chromium faucets, the wearing of zippers on clothing, and even the wearing of a platinum wedding ring may cause a troublesome and intractable skin eruption. Nickel sensitivity may be tested by strapping an *old* nickel to the skin overnight. (New nickels are said to contain little nickel.) A zipper rash usually follows the line of contact of the zipper to the skin.

Dr. Andrews told his hearers that of all skin eruptions diagnosed clinically as ringworm of the palms and soles, only about 25 per cent are actually ringworm. He said that a number of the remaining cases are *contact dermatitis,* and when recognized as such, are easily managed. Of the small percentage that remain, some are caused by internal focal infections and others by local streptococcic and staphylococcic infections.

Notwithstanding diagnoses to the contrary, many cases of severe itching and eruption on the feet are due not to fungus infection, but to the presence of anti-mildew compounds with which the lining of the patient's shoes has been treated. This eruption usually remains localized to the site of contact with such lining, the dorsal surface of the forefoot.

The speaker described a type of chronic eczema as being particularly identified with men in the forty-, fifty- and sixty-year age groups. These lesions usually appear on the legs, which accounts for their sometimes being mistakenly diagnosed as varicose eczema, even with little or no evidence of varicosity. This condition is frequently resultant upon caries of the teeth, and where it is observed, careful inquiry into the condition of the teeth often proves fruitful, and an x-ray examination of the teeth is definitely indicated.

5. Because of a prevalence in certain sections of this county of ringworm of the scalp, the speaker was asked to discuss this disease briefly. Following diagnosis by means of the Woods diagnostic lamp and microscopical examination, he said that *complete* epilation of the scalp is essential for cure. The patient's head must then be kept carefully covered by a stocking cap, and all necessary hygienic measures for his own protection, as well as in the interest of those with whom he comes in contact, must be conscientiously observed.

Asked for an opinion concerning "cable-rash", now being observed in shipyard workers, Dr. Andrews stated that these eruptions are caused by chlorinated naphthalenes and diphenyls in the insulation or in the lubricating oils. Those men who are found to be susceptible to this type of dermatitis should be warned of the necessity to change their occupation.

In concluding his presentation, Dr. Andrews showed an interesting series of lantern slides demonstrating various forms of sarcoid, necrobiosis, lymphogranuloma venereum, etc.

DRS. ALTER, MCNENNEY, FLIEGEL, RUOFF, CONTY and MATTHESHEIMER discussed the paper. Discussion was closed by Dr. Andrews.

## MONMOUTH COUNTY

Elsworth F. Baker, M.D., Reporter

The regular meeting of the *Monmouth County Medical Society* was held at the Nurses' Residence, Fitkin Memorial Hospital, Neptune, at 9:00 p.m., March 28, 1945. After a short business meeting, Dr. Harold Freedman of Freehold was asked to introduce the speaker of the evening, DR. ABRAHAM E. RAKOFF, Director of the Department of Endocrinology, Jefferson Medical College. Since his subject, "New Developments in Endocrinology", was such a large field, he stated that he would talk specifically on our present knowledge of the sex hormones of the female sexual cycle.

The anterior pituitary secretes the gonadotrophic hormones of which there are two, possibly three. First, the follicle stimulating hormone, and second, the luteinizing hormone but since both of these hormones are present in the male, they are better known as gametokinetic and interstitial cell stimulating hormones. In the female, secretion differs in that it is cyclic with an increasingly large outpouring of the gametokinetic hormone in the first half of the cycle for the purpose of stimulating development of the ovum. After ovulation there is an increase in the luteinizing hormone but a certain amount of both hormones are secreted at all times. Ovulation cannot occur under stimulation of the follicle stimulating hormone alone. After ovulation the luteinizing hormone produces the corpus luteum. The follicle, after it develops, produces its own hormones—estrogens—of which there are three: estrone, estriol and alpha-estradiol. These congregate in the liver and are excreted in the bile, re-absorbed and eventually are eliminated through the kidneys. Only 10 per cent of the original estrogenic activity is excreted in the urine. The rest is destroyed by metabolism in the body. The estrogens are steroids and chemically resemble cholesterin. They must, therefore, be given in fatty solution. The estrogenic peak is biphasic, the first peak

at ovulation and the second three or four days before the onset of menstruation following which there is a rapid estrogen withdrawal which is important in the onset of bleeding. The endometrium proliferates under estrogenic stimulation and the cells are nourished by coiled arterioles. These arterioles show a rhythmic contraction and expansion under extrogenic stimulation. When estrogen is removed, the arterioles contract and produce an ischemia of the endometrium which may last for several minutes at a time. This eventually produces disintegration of the endometrium so that when the arterioles fill again, bleeding occurs. In the male there is a constant secretion of hormones.

It must be remembered that hormones cannot be given without doing either good or harm so that considerable care must be used in their administration and it is extremely important to know what they are being used for. Considerable information can be obtained as to the hormone secretion by an endometrial biopsy. This, however, is a surgical procedure, expensive and temporarily disabling. Another method of obtaining information is by the extraction of estrogen from the urine, injecting it into mice or rats and obtaining smears from their vaginas for evidence of cornification. It would seem simpler to merely take a smear from the human vagina but this is not reliable because there is always cornification present due to the thickness of the cornified layer. However, considerable information can be obtained from the changes in the staining of the cells obtained from a vaginal smear. At the time of onset of menstruation and for the first five or six days the cells are consistently basophilic. They become eosonophilic towards the mid cycle, and after ovulation, the cells become cornified and curled, gradually returning to a basophilic state toward the onset of the following menstruation. Rather characteristic smears are obtained during pregnancy and at the menopause. One interesting point is that occasionally carcinoma cells may be found in the smears which may be the first indication of cancer of the uterus or cervix.

Progesterone prepares the endometrium for pregnancy. It is not found in the urine but its secretion can be measured by the amount of pregnandial in the urine. It is usually only necessary to estimate this hormone in the study of sterility or threatened abortion. In most cases it can easily be estimated by obtaining a basal rectal temperature in the morning before the individual gets out of bed. The day before ovulation there is a slight dip in the temperature and the day of ovulation the temperature rises by as much as one degree with a continued high temperature until the onset of menstruation. When the temperature fails to drop, pregnancy is present.

The female also secretes androgens which are secreted by the adrenal cortex. In the male two-thirds of the androgen secretion is from the adrenal cortex and one-third from the testes. Adrenal cortex activity can be detected in the female by an estimation of the androgens in the urine.

During the discussion which followed, Dr. Rakoff stated that we cannot use endocrines wisely unless we know what we are using them for, that they may always do harm. It has not been proven that estrogens are carcinogenic in the human, but they do stimulate cancer in carcinogenic mice. The danger in giving estrogens during the menopause is that we may produce bleeding and believe that it is from the estrogen, whereas, it may be cancer. Hormones should never be given unless we are certain that the pelvis is normal. They may stimuate fibroid growth and it is known that large doses of gonadotrophic hormones will produce ovarian cysts and ovarian hemorrhage. They should be given in doses to simulate the natural secretion of the body, that is, they are given for two weeks and stopped for two weeks. They should never be given more than three months at one time. Hormones could be used judicially during adolescence in cases of frequent and excessive menstruation. We find that the pituitary is usually functioning but the ovary is still not ready with estrogens. It is therapeutically sound to give estrogens but we must remember in so doing that we will very probably produce more bleeding with even danger of hemorrhage. Another approach is to give androgens which inhibit both the pituitary and bleeding but may produce masculinization. They should, therefore, be given only in small doses and the patient kept on the smallest amount to control bleeding and when menstruation is normal, they should be stopped altogether. They should always be stopped when the skin or scalp gets oily. This is the first sign of masculinization followed by acne, then hirsutism, deepening of the voice and enlargement of the clitoris. Oiliness of the skin and acne are reversible. The others are not. A girl may bleed from the opposite mechanism, that is, from poor gonadotrophic stimulation, and do well on gonadotrophic hormones.

A third group is where excessive bleeding occurs but where the pituitary is normal and there is also normal estrogenic secretion. This group is not very well understood but responds well to prolactin and there are no harmful effects in administering this hormone.

In cases of amenorrhea one should not be rash in inducing menstruation. A thorough physical examination must be done and one must also remember that amenorrhea may be psychogenic. One can afford to wait and eventually menstruation will occur. It is mostly a constitutional disorder where the individual has not grown up sufficiently. In the menopause, estrogen should be given only when symptoms really warrant treatment, that is, where the individual is really suffering and the pelvis must be normal. Then one should give the least amount that will almost control hot flashes. An occasional hot flash is all right, even desirable. The majority do well on oral administration and the natural estrogens are less toxic than the synthetic but more expensive.

Estrogens have been recovered from bile stones and since there is a high estrogenic activity in pregnancy, bile stones may result.

Hirsutism is frequently due to a functional imbalance of the hormones, that is, a low estrogenic secretion and normal androgens. Treatment is un-

satisfactory but estrogen administration seems to discourage the growth of new hair.

Dr. Rakoff illustrated his lecture with numerous lantern slides and both his very interesting lecture and his part in the lively discussion which followed in answering the numerous questions were highly appreciated. He was given a very sincere vote of thanks for his time and kindness in coming from Philadelphia to speak to the Society.

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The annual dinner meeting of the *Monmouth County Medical Society* was held at Joseph's Hunting Lodge, West Long Branch, at 8:00 p.m., April 25, 1945. The meeting was called to order following the dinner, DR. OTTO R. HOLTERS presiding.

The election was held for officers of the coming year. The following officers were elected:

President, DR. GRANVILLE L. JONES
President-Elect, DR. JAMES P. PREGNALL
Secretary-Treasurer, DR. LOUIS F. ALBRIGHT
Assistant Secretary-Treasurer, DR. ELSWORTH F. BAKER
Reporter, DR. F. LAWTON HINDLE
Delegates to the State Society: DRS. GRANVILLE L. JONES, WILLIAM G. HERRMAN
Nominating Delegate, DR. WILLIAM G. HERRMAN
Alternate Nominating Delegate, DR. OTTO R. HOLTERS
Executive Committee—
For three years: DRS. THOMAS H. ANDREWS, HAROLD H. FREEDMAN, ROBERT S. MCTAGUE
For two years: DR. HARRY R. BRINDLE
For one year: DRS. HOWARD C. BURKHEAD, WILLIAM MATTHEWS

Dr. Albright reported that we have 106 paid-up members in the Society, plus 50 members of the Society in the Armed Forces.

The following amended resolution was presented to the Society for consideration:

Whereas, The Board of Trustees of The Medical Society of New Jersey, because of the governmental regulations as to travel, have planned to act as the House of Delegates in May, 1945, which is of doubtful constitutionality and wisdom, and

Whereas, The A.M.A. has wisely solved the same difficulty by reducing their coming House of Delegates meeting to less than fifty delegates to meet governmental regulations;

Therefore, Be It Resoved by the Monmouth County Medical Society, That the Officers, Fellows, and Trustees of The Medical Society of New Jersey hold a regular meeting of the House of Delegates as usual by giving each of the County Societies one delegate, who shall be empowered to cast the number of votes normally entitled by the Delegates of that Society, thus reducing the House of Delegates within the government minimum of fifty, as the A.M.A. has done;

And Be It Resolved, That copies of this resolution be immediately forwarded to the President and Secretary of the other twenty County Societies and the President, Secretary, other Officers and Fellows of the State Society requesting that this democratic plan be promptly put in effect.

And Be It Further Resolved, That the Monmouth County Medical Society reserves the right to challenge any action taken by the Board of Trustees sitting as the House of Delegates.

It was moved by DR. HERRMAN, seconded by DR. JONES that this resolution be adopted. Motion was carried.

DR. HOLTERS spoke briefly on the National Physicians Committee and stated that this Committee should be supported.

DRS. PHILIP L. COSTA and FRANCIS W. HOLMAN were welcomed back into practice after having served in the Armed Forces.

Dr. Herrman called for a rising vote of thanks and an expression of our appreciation for the good services of our outgoing President, Dr. Otto R. Holters.

Our new President, DR. GRANVILLE L. JONES, pointed out some of the difficulties the medical profession faced at the present time, with a brief outline of his policies for the coming year. Both Dr. Holters and Dr. Jones were enthusiastically applauded.

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## PASSAIC COUNTY

J. Reuben Budd, M.D., Reporter

The regular meeting of the *Passaic County Medical Society* was held at the Board of Freeholders' Meeting Room, Administration Building, Paterson, on March 20, 1945. The meeting was called to order by the President, DR. WILLIAM M. SULLIVAN.

Dr. Sullivan introduced the speaker, DR. GEORGE F. HOCH, Attending Urologist at the St. Luke's and Women's Hospitals, New York, whose subject was "Office Procedure of Urology". Dr. Hoch pointed out that the general practitioner is the first to see most of the urological problems and can handle many of them; however, when a thorough urological survey is indicated the urologist should be called upon. Urological problems often enter in the differential diagnosis of the acute abdomen. It is common knowledge that the appendix is often removed without investigating the possibility of a ureteral calculus. In some instances, it is a routine procedure to take a flat plate of the abdomen to rule out a stone, in all cases of so-called "chronic appendicitis". The frequency of meteorism in renal pathology was stressed. A thorough discussion was given on the differential diagnosis and the importance of hematuria.

In discussing catheters, Dr. Hoch was opposed to the use of metal catheters because of the trauma to the urethra. Methylene blue in certain cases of bladder hemorrhages was considered valuable as a hemostatic agent. Dr. Hoch approved of Negatan in the treatment of trichomonas vaginalis. He pointed out that the success of treatment depended upon the treatment of the bladder at the same time.

The value of chemotherapy in urology was emphasized but the speaker stressed that chemotherapy did not change cardinal surgical princi-

ples. At the conclusion of the paper, urological instruments of value in office procedures were demonstrated.

Dr. Hoch's interesting and complete paper was discussed by Dr. Sidney Levine, Attending Urologist at the Paterson General Hospital.

Dr. Julian Cohen discussed the need for a convalescent home for rheumatic fever patients. He pointed out that many patients from our county have been sent to other institutions out of the county. He thought that a program to create this type of home must have the endorsement of the County Medical Society. Plans are still in their infancy and, at a later meeting, he will present a comprehensive outline of the problem so that the Society can act upon it.

At the business session of the meeting, the following doctors were elected to Active Membership in the Society: Fritz F. Adler, Richard Schoonover, Jeremiah H. O'Brian, Edna Charney Friedman, Louis S. Saco.

## WARREN COUNTY

Philip B. Kassow, M.D., Reporter

The *Warren County Medical Society* held its meeting at the Meadowbrook Restaurant in Phillipsburg on April 18, 1945.

Drs. Eugene Cioffi of Washington and Hubert J. Adler of Phillipsburg were admitted to membership.

Dr. B. M. Hance of Easton, Pa., delivered an interesting talk on "Nephroptosis". He stated that there is a division of opinion on the treatment of this condition. Many vague symptoms are caused by this condition. Stout as well as lean persons may suffer from it. Nephroptosis basically is caused by an anatomical deficiency. Dr. Hance also stated that usually in most cases complete or partial relief is elicited upon placing the patient in a prone position.

Fourteen members were present.

The meeting was concluded with a luncheon for the members and the Woman's Auxiliary joined them.

## SUMMIT MEDICAL SOCIETY

Carrol S. Thomson, M.D., Secretary

The fifth meeting of the *Summit Medical Society* was held in the lecture room of the Ciba Pharmaceutical Products, Inc., on Tuesday evening, March 27, 1945. Twenty-two members and ten guests were present.

The minutes of the last meeting were read, in which was incorporated the resolution on the death of Dr. Hugh D. Jamison. The resolution, which was signed by Drs. T. P. Prout and C. B. Keeney, was adopted by the Society.

Dr. M. S. Edgar then introduced Dr. J. Ward MacNeal, Professor of Bacteriology, New York Post-Graduate School, who discussed "Progress in the Study of Endocarditis".

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The *Summit Medical Society* held its sixth meeting of the season on April 24, 1945, at 9:00 p. m. at The Ciba Pharmaceutical Products Co., with 23 members and ten guests present.

Dr. William H. Lawrence, who was prominent in his profession and practiced medicine and surgery for many years in Summit, was notified at his new home in Maine that he had been elected an honorary member of the Society. Due to the many applications requesting membership in the Society, it was decided to increase the number of active members to fifty.

The Society has invited the Mental Hygiene Society of Union County to take part in the May meeting.

Dr. Maurice Lesser of Boston, Mass., presented a very interesting paper on "Angina Pectoris Treated by Testosterone Proprionate". This paper evoked much discussion.

Dr. Oppenheimer of the Ciba Company was unanimously elected an active member.

Dr. M. S. Edgar appointed a committee to meet with the Board of Health of the City of Summit, to consider a revision of the Quarantine Laws.

After the meeting a collation was served.

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# BOOKS RECEIVED FOR REVIEW

Examination of Reflexes; a Simplification. By Robert Wartenberg, M.D., with a foreword by Foster Kennedy, M.D. Pp. 222. Chicago, Year Book Publishers, Inc. 1945. $2.50.

Mass Radiography of the Chest. By Herman E. Hilleboe, M.D., and Russell H. Morgan, M.D. Pp. 288, illustrated. Chicago, Year Book Publishers, Inc. 1945. $3.50.

Doctors at War. Edited by Morris Fishbein, M.D. Pp. 418, illustrated with photographs and charts. New York, E. P. Dutton. 1945. $5.00.

Penicillin and Other Antibiotic Agents. By Wallace E. Herrell, M.D., M.S., F.A.C.P. Pp. 345 with 45 illustrations. Philadelphia & London, W. B. Saunders Company. 1945. $5.00.

Dietotherapy: Clinical Application of Modern Nutrition. Edited by Michael G. Wohl, M.D., with a foreword by Russell M. Wilder, M.D., Ph.D. Pp. 1029 with 93 illustrations. Philadelphia & London, W. B. Saunders Company. 1945. $10.00.

Trauma in Internal Diseases with Consideration of Experimental Pathology and Medicolegal Aspects. By Rudolf A. Stern, M.D., with a foreword by Francis Carter Wood, M.D. Pp. 575. New York, Grune & Stratton, Inc. 1945. $6.75.

Constitution and Disease: Applied Constitutional Pathology. By Julius Bauer, M.D. 2d ed. Pp. 247. New York, Grune & Stratton, Inc. 1945. $4.00.

Penicillin Therapy, Including Tyrothricin and Other Antibiotic Therapy. By John A. Kolmer,

M.S., M.D., Dr. P.H., Sc.D., LL.D., L.H.D., F.A.C.P. Pp. 302, illustrated. New York, D. Appleton-Century Company. 1945.

Clinical Roentgenology of the Digestive Tract. By Maurice Feldman, M.D. 2d ed. Pp. 769, illustrated. Baltimore, Williams & Wilkins Company. 1945. $7.00.

My Second Life. By Thomas Hall Shastid, A.M., M.D., LL.B., Sc.D., F.A.C.S., F.A.C.P., etc. Pp. 1174, illustrated. Ann Arbor, George Wahr. 1944. $10.00.

Textbook of Ophthalmology. By Sanford R. Gifford, M.A., M.D., F.A.C.S. 3d ed. Pp. 457 with 215 illustrations and 13 color plates. Philadelphia & London, W. B. Saunders Company. 1945. $4.00.

Preventive Medicine. By Mark F. Boyd, M.D., M.S., C.P.H. 7th ed. Pp. 591 with 187 illustrations. Philadelphia & London, W. B. Saunders Company. 1945. $5.00.

Physical Diagnosis. By Ralph H. Major, M.D. 3d ed. Pp. 444 with 458 illustrations. Philadelphia & London, W. B. Saunders Company. 1945. $5.00.

Management of Obstetric Difficulties. By Paul Titus, M.D. 3d ed. Pp. 1000 with 426 illustrations and 8 color plates. St. Louis, C. V. Mosby Company. 1945. $10.00.

## BOOK REVIEWS

**Synopsis of Neuropsychiatry.** By Lowell S. Selling, Sc.D., M.D., Ph.D., Dr. P.H. Pp. 500. St. Louis, C. V. Mosby Company. 1944. $5.00.

This is an excellent synopsis. It is orderly in its presentation of material and pertinent facts are briefly and concisely stated. An innovation is the inclusion of short statements of the military and medico-legal significance of various disorders.

The greater part of the synopsis is devoted to neurology but the section on mental disorders is adequate. The portion dealing with descriptions of the psychopathic personality is particularly good.

J. W. Kinley, M.D.

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**Electrocardiogram:** Its Interpretation and Clinical Application. By Louis H. Sigler, M.D., F.A.C.P. Pp. 403, illustrated. New York, Grune & Stratton. 1944. $7.50.

For excellence of presentation Sigler's Electrocardiogram is probably unsurpassed in its field. It is written in a clear and concise style which makes a highly technical subject actually enjoyable reading. Although the author has made numerous original contributions to the literature in the past, his present volume follows conventional lines and offers no innovations. Important chapters are introduced by a short historical note which reviews the pertinent literature. The bibliography is well selected. Where possible a physiological explanation for the electrocardiographic changes is attempted. The chapter on bundle branch block is particularly well done, and the discussion of trauma of the heart will be of value to practitioners who are interested in the medico-legal aspects of heart disease. The concept that the pattern of pericarditis is due to subpericardial myocarditis is emphasized. While this view is undoubtedly correct, it would perhaps be preferable to assign to the subject of pericarditis an individual chapter, rather than to include it under the general heading of myocarditis.

There are few statements in this text to which one may take exception. In discussing the effect of quinidine upon auricular fibrillation the author says that the ventricular rate is often increased, "due to the effect that with slowing of the auricular rate, the auricular impulses become stronger and more effective and therefore a greater number of them are transmitted to the ventricules". That an auricular impulse may vary in intensity or effectiveness probably has no basis in fact.

The illustrations are adequate, but not uniformly technically perfect. This book is enthusiastically recommended both to students and to experienced cardiologists.

Ralph Miller, M.D.

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**Lead Poisoning.** By Abraham Cantarow, M.D., and Max Trumper, Ph.D. Pp. 264. Baltimore, Williams & Wilkins Company. 1944. $3.00.

An excellent discussion of the problem of lead poisoning is contained in this rather small monograph. It is to be highly recommended to anyone interested in this field. Primarily the book is a review of the literature and an extensive bibliography is appended. However, the authors have exercised good judgment in the selection of material. There are chapters on the metabolism of lead, pathology and pathological physiology, the clinical picture of lead poisoning, the normal content of lead in body fluids and excretions and the treatment of lead poisoning. A discussion of lead in industry is included as well as a chapter on various laboratory procedures by Morris B. Jacobs.

Louis Grunt, M.D.

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**Manual of Tropical Medicine;** Prepared under the Auspices of the Division of Medical Sciences of the National Research Council. By Colonel Thomas T. Mackie, M.C., A.U.S.; Major George W. Hunter, III, Sc.C., A.U.S., and Captain C. Brooke Worth, M.C., A.U.S., with the collaboration of Colonel George R. Callender, M.C., A.U.S.; Colonel Richard P. Strong, M.C., A.U.S.; Colonel Harry Plotz, M.C., A.U.S.; Major Gordon E. Davis, Sn.C., A.U.S.; Captain Elery R. Becker, Sn.C., A.U.S., and Captain Luther S. West, Sn.C., A.U.S. Pp. 727; illustrations, 287, 6 in color. Philadelphia & London, W. B. Saunders Company. 1945. $6.00.

For a text book, this one is concise, precise, complete and exceptionally up-to-date. For those with a photographic mind it is particularly beneficial since the circular pictures summarize each disease in a manner in which it can be most easily retained. To this reviewer it has been of great benefit as a method of review in preparation for my talks on tropical diseases.

Julius Sobin, Lt. Col., M.C., A.U.S.

# WOMAN'S AUXILIARY

## MRS. WILLIAM E. DODD

### 1945-46 President

Mrs. William E. Dodd, a daughter of the late Mr. and Mrs. Job White, was born in Wiconisco, Pennsylvania. She attended the public schools of Wiconisco and after graduation from high school entered the Lankenau Hospital Training School for Nurses in Philadelphia. At that time our country was engaged in World War I and nurses were badly needed by the Armed Forces. It was Mrs. Dodd's intention to become an Army Nurse but by the time she had graduated the War was over and this ambition was never realized; instead she served in a supervising capacity at the Lankenau Hospital for several years.

On April 25, 1923, she married Dr. William Earle Dodd and went to live in Rossiter, Pennsylvania, where Dr. Dodd was then practicing. Two sons were born to them who are now serving in the Armed Forces. In 1930 Dr. and Mrs. Dodd moved to Beach Haven where they now live.

Mrs. Dodd has always taken an active part in the affairs of her community. She has served as a member of the Board of Education of Beach Haven; she has been active in local and county Parent-Teacher organizations; and she has served as a member of the Directing Board of the Kynette Methodist Church, Beach Haven, of which she is a member.

Mrs. Dodd has devoted much of her time to Red Cross activities. She organized and has supervised the various groups of workers engaged in the preparation of surgical dressings on Long Beach Island. She is Chairman of the Committee engaged in securing blood donors for our Armed Forces. She has taught classes in Home Nursing and serves as a nurse assigned to a local casualty station of the Civilian Defense.



Mrs. Dodd has served two years each in the offices of Treasurer, Secretary and President of the Woman's Auxiliary to the Ocean County Medical Society. As Revisions Chairman, Historian and Director she has served the Woman's Auxiliary to The Medical Society of New Jersey.

## AUXILIARY REPORTS

### Atlantic County

Mrs. Samuel Salasin, Chairman of Publicity

The jewelry industry was one of the first to be sacrificed during the war, Mrs. Luella Koons, local jeweler, told the *Woman's Auxiliary to the Atlantic County Medical Society* Friday afternoon, April 13, 1945, in the Dolly Madison Room of the Madison Hotel.

Mrs. Koons' talk on the "Romance of Silver" ventured into the history and the background of silver, bringing it up to current problems and needs.

In order to cope with the tight war situation, many manufacturers confined the number of items made and limited the number of patterns to eight, she said. There was a restriction on the making of odd pieces and only the more economical ones were produced, Mrs. Koons explained.

Mrs. Bernard Crane announced, prior to Mrs. Koons' talk, that the book, "Mosquitoes of New Jersey and Their Control", which had been purchased in memory of Dr. Kenneth Henderson and Dr. Woodburn J. Hudson, had been presented by

her, in behalf of the Auxiliary, to the Atlantic City Hospital Library.

Mrs. E. G. Shreve, a director of the Atlantic County Public Health Service, made an appeal for the assistance of the women in the coming Cancer Control Drive. Mrs. Shreve is the Atlantic County Commander of the Cancer Control Drive.

### Essex County

Mrs. Rocco Marra, Chairman of Publicity

The *Woman's Auxiliary to the Essex County Medical Society* held the last of three symposia on Monday, March 27, 1945, at 2:30 p.m. in the Academy of Medicine. Guest speakers were: Dr. James S. Plant, Director of Essex County Juvenile Clinic; Dr. Lloyd Yepson, Director of Education and Classification in the State Department of Institutions and Agencies; and The Honorable Felix Forlenza, former judge of Essex County Domestic Relations and Juvenile Court.

The general topic was "Child Health and Behavior". In addition to regular members of the Auxiliary, many social workers, parents and teachers attended. Dr. Plant presented the psychiatric side of child health. He said psychiatrists realize that much could be done in childhood to prevent later mental breakdowns. He asserted psychiatrists have far to go in studying childhood reactions, and little is known of the reaction of illness on the mental condition of a child.

The reaction of illness on the child's behavior was discussed by Dr. Yepson. "Every physician," he said, "has had the experience where a child during a long illness became a different type of child. Patterns of behavior built up during illness may become fixed."

Judge Forlenza showed how the juvenile court is set up to find the cause of children's behavior. Its purpose is not to punish, but to cure, he asserted. The court does not attempt to do case work, but obtains the assistance of other agencies. In this connection Judge Forlenza commended the aid of Dr. Plant and Joseph F. Murphy, chief county probation officer. The addresses were followed by general discussion.

Preceding the meeting, Mrs. Lodovico Mancusi-Ungaro, Auxiliary President, was hostess at a luncheon of board members in honor of Mrs. David B. Allman of Atlantic City, President of the State Auxiliary.

Mrs. S. Bernard Kaplan of Newark, Chairman of the Public Relations Committee, presided.

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The Woman's Auxiliary and the College Woman's Club of Essex County had a joint meeting April 23, 1945, at 8:00 p. m. at the Academy of Medicine. Guest speakers included: Dr. Joseph L. Echikson, Chairman of the Cancer Committee of Essex County Medical Society, and Mrs. A. Haines Lippincott of Camden, Commander for the State of New Jersey Women's Field Army of the American Cancer Society.

Dr. Echikson pointed out that there is much hopefulness in the outlook for the control of cancer. Tuberculosis is now practically under control, the speaker asserted, and progress made in the study and treatment of cancer gives promise of equal success. A point stressed by Dr. Echikson was lack of provision for care of these cases. The State has no institution specificially devoted to cancer cases. Mrs. Lippincott stressed the importance of early care and treatment, speaking of the successful work of cancer clinics in Philadelphia. "We are at war against a tremendous enemy of mankind," she declared. "I am interested in preventing deaths of people needlessly."

Mrs. Lodovico Mancusi-Ungaro, President of the Auxiliary, presided. She presented Dr. Louis Schneider, President of the Essex County Medical Society, and Mrs. Alan Johnson, President of the College Woman's Club of Essex County.

Mrs. William Donahue, member of the Hostess Committee, planned a delightful and appetizing supper and dessert, which was served prior to the meeting and enjoyed by everyone. Members of both organizations assisted with the serving. Ninety-two were present for supper and 150 for the lecture.

### Gloucester County

Mrs. C. A. Bowersox, Press and Publicity Chairman

A special meeting of the *Woman's Auxiliary to the Gloucester County Medical Society* was held at the home of the President, Mrs. Henry B. Diverty, Woodbury, on Friday, March 23, 1945, at 3:00 p.m. There were six members present. Plans were discussed for the "Reciprocity Tea" to be held on April 26, 1945.

Mrs. Diverty and Mrs. C. I. Ulmer attended the regular open business meeting of the State Auxiliary in Trenton on Monday, March 12, 1945. Mrs. Ulmer also attended the Camden County Auxiliary tea, held on March 20, 1945.

### Mercer County

Mrs. C. Chester Chianese, Chairman of Publicity

A regular meeting and card party of the *Woman's Auxiliary to the Mercer County Medical Society* were held in the Executive Offices of The Medical Society of New Jersey Friday, April 6, 1945. Mrs. H. Donald Cowlbeck presided.

The business session took place at 1:00 p. m. and at that time annual reports were given by committee chairmen. At 2:00 p.m. members played cards. Mrs. Patrick Corrigan, Chairman of the Entertainment Committee, was assisted by Mrs. C. Chester Chianese and Mrs. Ernest Purcell. Refreshments were served at 4:00 p.m.

### Middlesex County

Mrs. Norman Rosenberg, Chairman of Publicity

Mrs. L. A. M. Feher was hostess to the members of the *Woman's Auxiliary to the Middlesex County Medical Society* Wednesday evening, March 21, 1945, when arrangements were made to begin a new project at the next meeting—that of making cancer dressings for indigent cancer patients. Following the business meeting, conducted by the President, Mrs. Charles Merrill, the postponed auction sale

was held. Mrs. F. M. Hoffman and Mrs. B. M. Howley were assistants to the hostess at the tea which followed the meeting.

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The April meeting of the Auxiliary was held Wednesday afternoon, April 18, 1945, at 2:00 p.m. at Merriewold, former residence of John Seward Johnson, Vice-President of Johnson and Johnson, which has now become a nursing home. Each member was permitted to invite a guest. Following a tour of Merriewold, there was a meeting of the Auxiliary. A demonstration was given on the making of dressings for indigent cancer patients so that the work could be continued at home individually or at meetings. Tea was served.

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### Monmouth County

Mrs. Maxwell Colby, Chairman of Publicity

Mrs. Thomas Andrews, Matawan, was elected President of the *Woman's Auxiliary to the Monmouth County Medical Society* at the annual meeting of that Society held at Auxiliary Hall, Long Branch, Tuesday, April 10, 1945. She succeeds Mrs. Joseph Bossone of Long Branch, who was named Chairman of the Medical Society's Blood Transfusion Fund.

The election was supervised by Mrs. J. Howard Hornberger, Burlington, Chairman of Organization for the State Auxiliary, who stressed the need for the blood transfusion fund and suggested ways in which to raise money.

The President-Elect for next year is Mrs. Benjamin Daversa, Spring Lake. Other officers chosen include Mrs. James Pregnall, Deal, Vice-President; Mrs. James A. Fisher, Interlaken, Corresponding Secretary; Mrs. Louis Albright, Spring Lake, Recording Secretary; Mrs. F. Lawton Hindle, Red Bank, Treasurer.

Mrs. David Diamond of Oceanport was hostess at the tea which followed the meeting.

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### Passaic County

Mrs. Irving Silverman, Chairman of Publicity

Preceding the Public Relations Meeting of the *Woman's Auxiliary to Passaic County Medical Society* a meeting was held Monday, March 13, 1945, at the home of Mrs. Dean A. Wry, Clifton, to formulate plans for that meeting. Mrs. R. J. McDonald reported on the March State meeting, and Mrs. Richard White reviewed the book "The Immortal Wife" by Irving Stone. Tea followed the meeting.

On Monday, April 16, 1945, the Auxiliary held an open meeting at the Paterson Public Library with Dr. Julian Cohen, Chairman of the Heart Disease Committee of the Passaic County Medical Society, and also Chairman of that same committee for the Passaic County Tuberculosis and Health Association, speaking on Passaic County's need for a heart foundation where children suffering with rheumatic heart disease may receive the convalescent care that they need.

Since June of 1940, 136 children have been sent out of Passaic County for treatment because there is no place for them here. The best treatment for rheumatic fever patients to prevent recurring attacks which in time may prove fatal, is adequate and proper convalescent care under the supervision of physicians and nurses. This care often extends into months and years. The city hospitals are crowded and can do no more than see the child through the acute stage, when he is then sent home, often to exposure from other members of the family to colds which to the rheumatic fever patient leads to future attacks.

Passaic County needs a hospital or pavilion, with facilities for caring for at least 30 patients. The ideal site for such an institution, Dr. Cohen said, would be either at Hope Dell or Valley View, but the present facilities there are overtaxed and the only solution would be a new building or a reconverted building now in existence. In answer to a question from the audience, Dr. Cohen estimated that the initial cost for such a venture would be approximately $150,000. Its upkeep would run about $2.75 per day per patient.

The picture "Your Life Depends On It" was shown, and the essence of Dr. Cohen's lecture was forcefully demonstrated by this film which was made by the Cardiac Committee of the Tuberculosis and Health Association of this county. Dr. Cohen supplied the narration in the film.

At the close of the meeting a spirited discussion was engaged in by the guests and Dr. Cohen, the intelligent nature of the questions testifying to the interest which had been aroused by the evening's lecture.

Mrs. R. J. McDonald, Chairman of the Volunteer Corps for the Campaign Committee of the American Cancer Society, gave a brief talk on the current campaign and she appealed for volunteers to solicit funds for this worthy endeavor, the ultimate defeat of cancer.

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### Warren County

Mrs. Herman Baldauf, Chairman of Publicity

The annual meeting and election of officers of the *Woman's Auxiliary to the Warren County Medical Society* was held April 16, 1945, at the Meadowview Restaurant, and the following officers were elected: Mrs. F. A. Shimer, President; Mrs. Ralph Buchanan, First Vice-President; Mrs. Mary Hackett, Second Vice-President; Mrs. Paul Drake, Treasurer, and Mrs. Elizabeth Curtis, Secretary.

A committee was appointed to determine the needs of the Warren County Hospital, so as to spend the funds raised by the Auxiliary to the best advantage of the hospital.

After the business session the women had luncheon with the members of the County Medical Society. The guests of honor were Mrs. David B. Allman of Atlantic City, President of the State Auxiliary, and Mrs. William E. Dodd of Beach Haven, President-Elect of the State Auxiliary.

# Tuberculosis Abstracts

*A Review for Physicians*

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

**Vol. XVIII** **June, 1945** **No. 6**

MANY reports, often contradictory, have appeared concerning the effect of the war on the tuberculosis death rate. News from some of our crowded centers of war production has been discouraging. The press has featured alarming dispatches about appalling conditions in war-torn areas abroad. A few domestic analyses have sounded unduly optimistic. For these reasons, hard-pressed physicians will welcome a sensible, factual statement of the status of tuberculosis mortality in the United States at the present time.

## THE TUBERCULOSIS DEATH RATE IN WARTIME

As the war has progressed, persons interested in the problem of tuberculosis control, and in fact the general public, have evinced considerable concern regarding the trend of the country's death rate from tuberculosis.

Inasmuch as war conditions usually lead to an increase in the incidence of tuberculosis a rise in the death rate was to be expected in 1943, the second full year of American participation in the war. For this reason the decline registered is even more encouraging than those recorded in previous years. In view of the chronic nature of the disease, however, several years may elapse before the impact of war conditions is reflected in a mortality rise. Therefore, we must all realize that the probability of an increase in the incidence of tuberculosis is enhanced each day the war continues.

The decline in tuberculosis mortality has continued steadily each year since 1936 and, with the exception of two minor interruptions, each year since 1918. These sustained decreases must be attributed to quite a number of factors, among which are:

1. Greatly improved and enlarged facilities for the care of the tuberculous, including better managed sanatoria and thousands of additional beds; a higher standard of clinic service and of public health nursing service, as well as a great improvement in health administration generally.

2. Earlier diagnosis and improved methods of diagnosis, including mass X-ray surveys among apparently healthy adults.

3. Recognition on the part of patients and their families of the importance of sanatorium care with the result that a much larger proportion of infectious patients have been segregated, thus minimizing the spread of the disease.

4. Increasing awareness of the tuberculosis problem and acceptance of the greatly amplified program of health education.

5. Decided improvement in the standard of living throughout the country.

6. Intensive efforts directed toward certain groups, such as high school and college students, medical students, nurses, expectant mothers, and young women generally. More recently these efforts have been directed toward industrial employees, Negroes and Spanish-speaking people, and men and women who are being examined for service in the armed forces.

The most interesting trend noted in 1943 is the fact that so many of these increased death rates are concentrated in the industrial states of the northeastern and north central sections of the country, while, on the other hand, even more pronounced declines are noted in the states of the south and west.

According to one theory, these increased rates in our industrial states may indicate rising mortality from tuberculosis in the country as a whole. Others are of the opinion that the stupendous migration of the past few years may have resulted in a realignment of the American people—to some extent, at least, on health grounds. Only time can determine which of these two hypotheses is correct.

The abnormal conditions incident to the war have affected the population distribution in the states more than is usually realized. Internal migration, both civilian and military, has resulted in decreased population in the northeastern and north central states, while in the south and west the population has increased materially since the date of the last decennial census in 1940.

The assignment of millions of the country's healthiest young men and young women outside continental United States and the elimination of their number from population estimates upon which death rates are based, have had the effect of raising tuberculosis mortality slightly in the country as a whole. Many more millions of our healthiest young citizens have likewise been assigned to training camps which are largely concentrated in the states of the south and far west, where climatic conditions facilitate military training throughout all months of the year.

Since all (or approximately all) of these young people had been recently X-rayed it is highly probable that the deaths from tuberculosis among their number would have been negligible in 1943; yet 2,500,000 of them were eliminated from the population base on which the death rate is computed.

Simultaneously other millions of all ages whose state of health is unknown have migrated to and fro without pattern in search of industrial employment. It is quite possible that this population upheaval, which has no parallel in American history, will affect the trend of tuberculosis mortality in the states for years to come.

The difficulties of computing sound death rates in these days of major population shifts cannot be appreciated until one makes an effort to obtain population estimates for a given date, to evaluate the extent of the changes in a given community, and to analyze the effect of the population changes on the death rates.

Changes in the size of a state's population are allowed for when death rates are computed on the basis of the best available population estimates. But changes in the age, sex and color composition of the population cannot be taken into consideration until a new population census has been taken. Obviously, no population census will prove to be worth while until the people of the country have had a few years to settle down after the war.

*What Is Happening to the Tuberculosis Death Rate? Mary Dempsey, American Review of Tuberculosis, December, 1944.*

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*"Bactericidal Efficiency of Iodine Solutions and Organic Mercurial Antiseptics", Amer. Jour. Pharm., 117:5 (Jan.) 1945.

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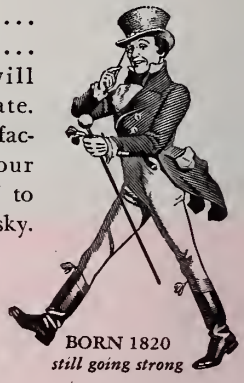


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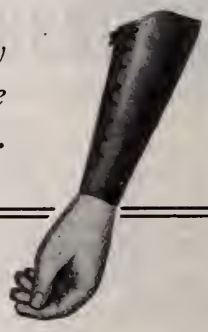
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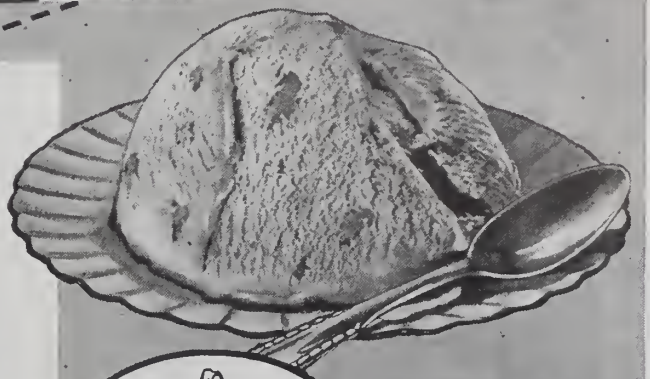
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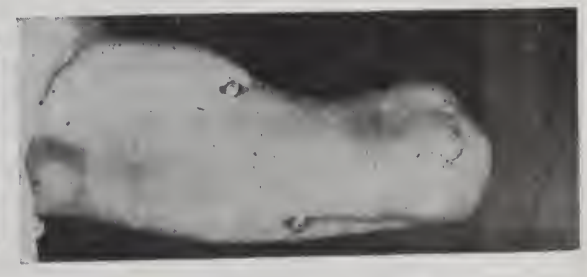
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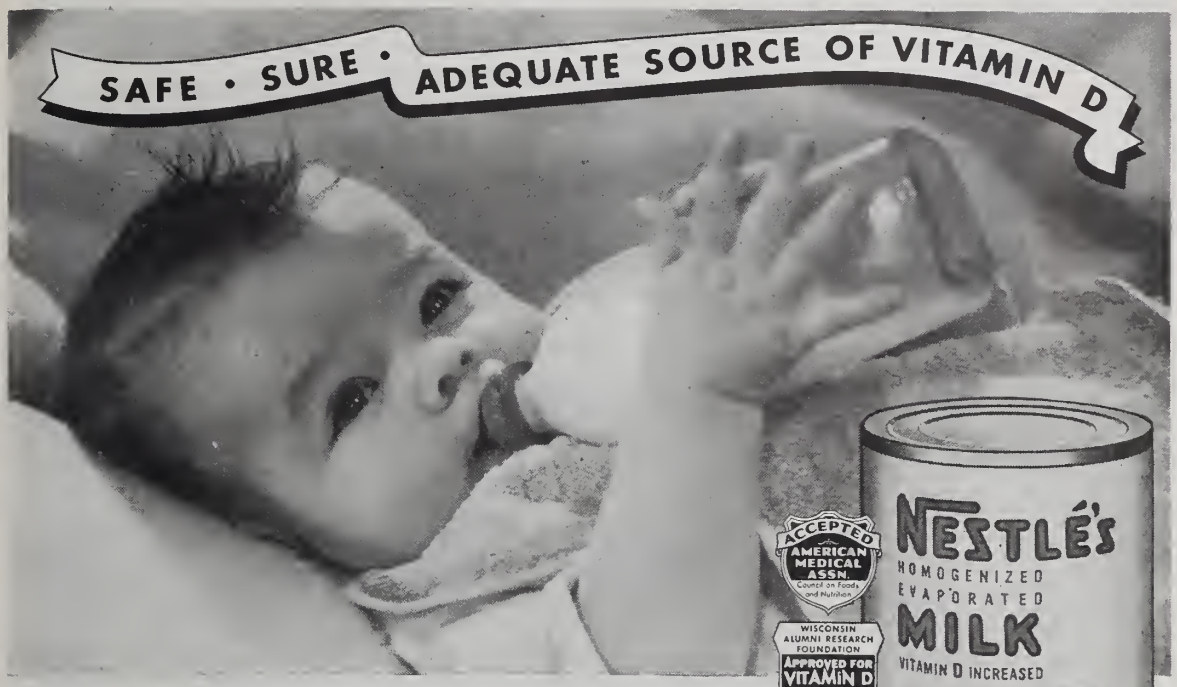
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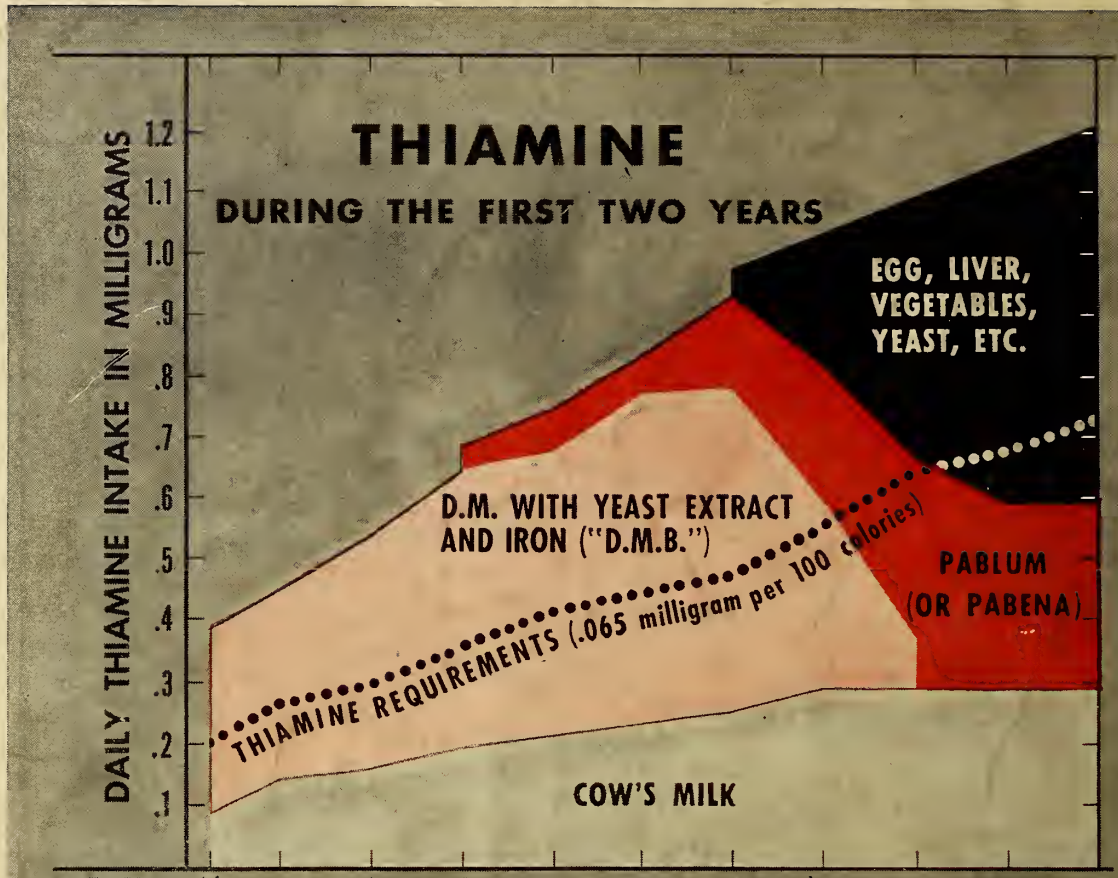
1. Compton, B. C.; Bieren, R. E.; Jones, E. G.; Inloes Jr, B. H.; Kordash, T., ond Hundley, J. M.: Treatment of Gonococcic Vulvovoginitis, *J.A.M.A.* 127:6 (Jan. 6) 1945.

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*X-Ray of patient with visceroptosis. (Left) The lesser curvature of the stomach is below the crests of the ilia. (Right) X-Ray of same patient after application of Camp Support for visceroptosis indicating how the viscera is held in a more nearly normal position.*

# Visceroptosis Support – CAMP

The roentgenologist may or may not find disturbed conditions in the duodenum... the displaced viscera being the only finding. For these patients, many physicians prescribe adequate rest, proper food at regular intervals, graduated exercises (especially for the patient with "visceroptotic habitus"), and a scientifically designed anatomical support. Numerous reports show that this treatment results in the gradual disappearance of the digestive symptoms with improvement in general health and weight gains for the thin patient. In time the support may be discarded.



*Camp supports for visceroptosis are fitted and adjusted with the patient in the partial Trendelenburg position. Pads are frequently used under the direction of the physician.*

Camp Supports are also of assistance for postural defects that so frequently accompany the visceroptotic condition.

S. H. CAMP & COMPANY • Jackson, Mich. • *World's Largest Manufacturers of Scientific Supports*

*Offices in* NEW YORK • CHICAGO • WINDSOR, ONTARIO • LONDON, ENGLAND



DRAWING—FATTY, OBESE TYPE

PHOTOGRAPH—PATIENT WITHOUT BREAST SUPPORT.

PHOTOGRAPH—SAME PATIENT AFTER APPLICATION OF BREAST SUPPORT

# *BREAST SUPPORTS*

## FOR THE HEAVY BREAST

To better balance the weight of the heavy mammary gland, these breast supports made by Camp are provided with very light buckles through which the lacings in the back glide. This brings the portion of the support under the bust compartment and the lower portion of the back of the support together evenly and assists in steadying the breast in position on the chest wall. An elastic inset is placed at the top of the support in the back.

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# *When Weight Gains*

## ARE NEEDED

For the underweight patient just recovered from severe acute or chronic illness, increase in weight may be difficult to achieve with the customary high-caloric diet. Yet restoration of normal fat deposits and correction of nutritional deficiencies are essential for rapid return of strength and resistance to infection.

The intake of essential nutrients high in calorific value is expeditiously accomplished by including Ovaltine in the diet. This tasty food drink, made with milk as directed, is enjoyed by all patients both as a mealtime beverage and between meals. Not only rich in calories, it also provides generously other nutrients urgently required: biologically adequate proteins, highly emulsified fat, B complex and other vitamins, as well as the essential minerals iron, copper, calcium, and phosphorus. The low curd tension of Ovaltine favors quicker gastric emptying, hence the appetite actually tends to become enhanced through this desirable behavior.

**THE WANDER COMPANY, 360 N. MICHIGAN AVE., CHICAGO 1, ILL.**




# *Ovaltine*

Three daily servings of Ovaltine, each made of ½ oz. Ovaltine and 8 oz. of whole milk,* provide:

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| PROTEIN | 31.2 Gm. | VITAMIN A | 2953 I.U. |
| CARBOHYDRATE | 62.43 Gm. | VITAMIN D | 480 I.U. |
| FAT | 29.34 Gm. | THIAMINE | 1.296 mg. |
| CALCIUM | 1.104 Gm. | RIBOFLAVIN | 1.278 mg. |
| PHOSPHORUS | .903 Gm. | NIACIN | 7.0 mg. |
| IRON | 11.94 mg. | COPPER | .5 mg. |

*Based on average reported values for milk.

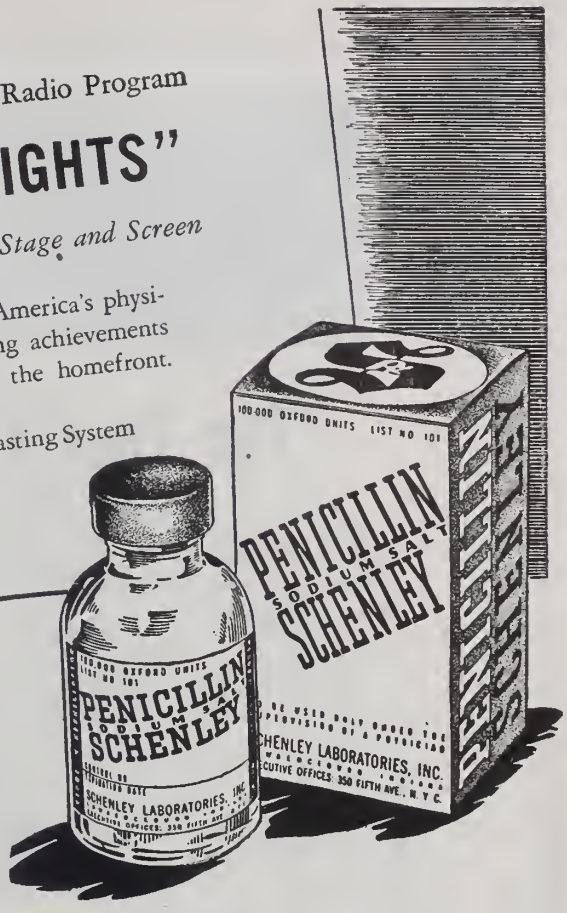
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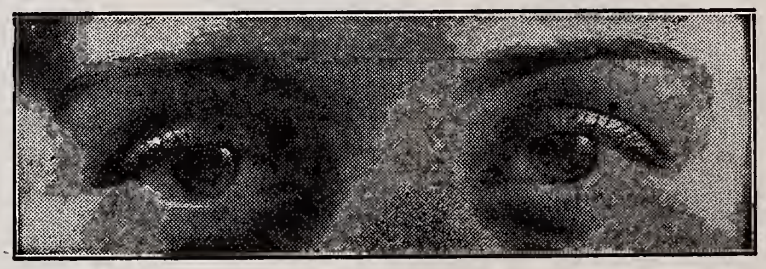
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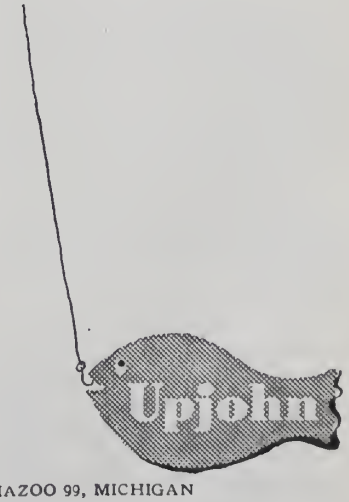


When Summer Rolls Around

Vitamin D cannot be given a vacation, because supplementation is as important in the summer as it is in winter. In substantiation, leading nutritionists point to the presence of rickets in sunny California,[1] and to the danger of breaking a good habit once it is developed.[2]

Upjohn's vitamin preparations assure potent, natural vitamin D supplementation which, even on the hottest days, can be well tolerated by the youngest of infants.

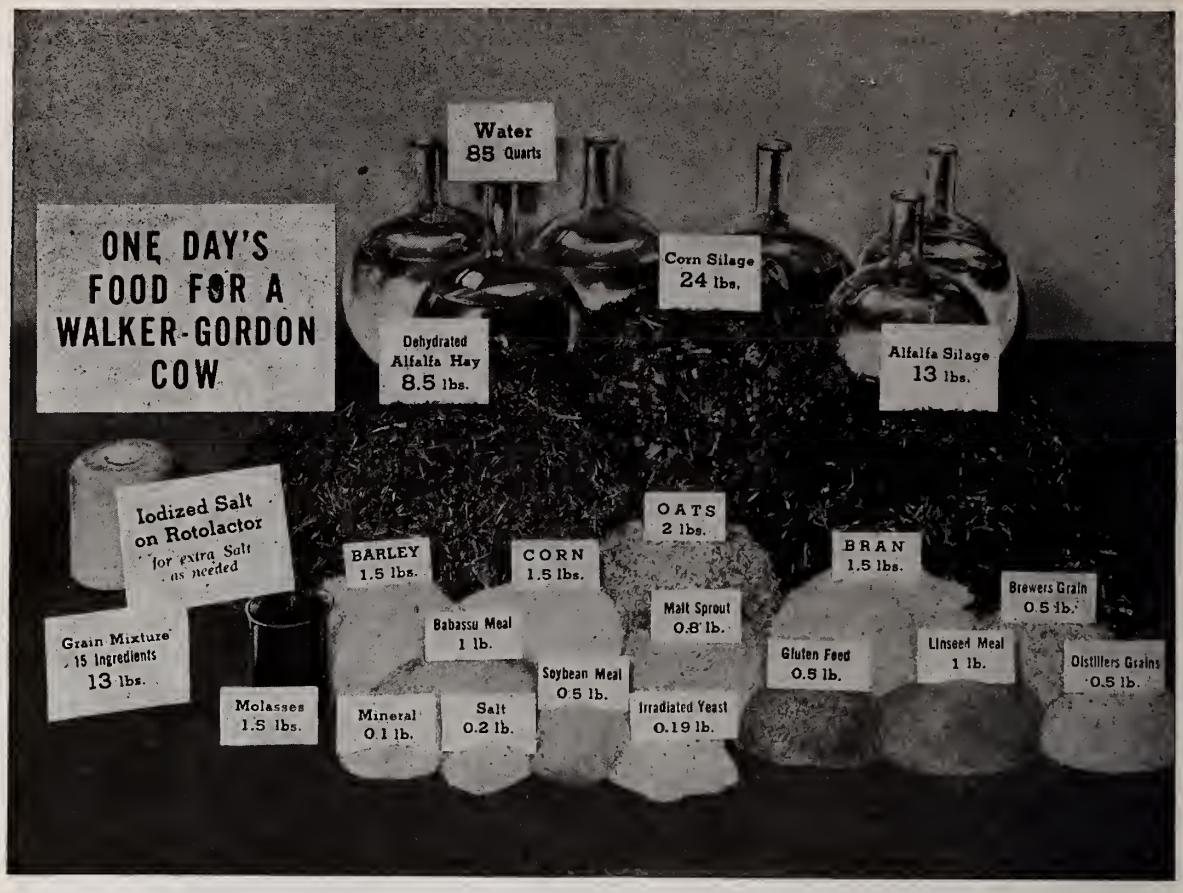
Upjohn Vitamins




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1. Am. J. Dis. Child. 54:1227, 1937. 2. The Vitamins, Chicago, American Medical Assn., 1938, p. 524.




# How many cows get a scientific ration like this?

THIS SCIENTIFIC daily ration was developed after years of study by the Walker-Gordon Laboratories.

It's remarkably rich in vitamins and health-giving minerals . . . And that's *one* big reason why Walker-Gordon cows produce a milk far superior to the type you get from cows that are fed in the ordinary, unscientific way.

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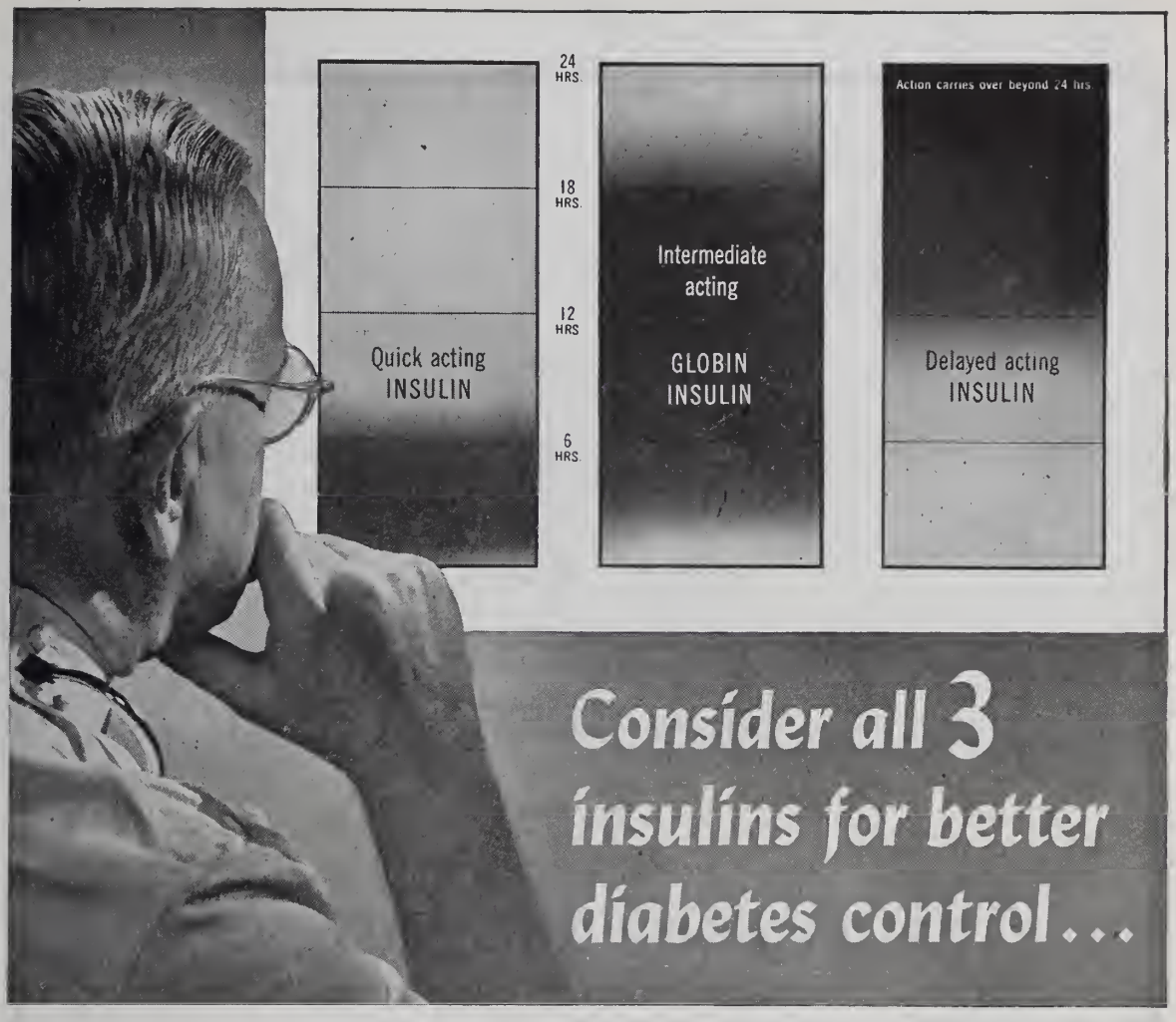
And though the quantity of some other vitamins varies in ordinary milk (according to the season and what the cows find to eat), *the vitamin content remains uniformly high in Walker-Gordon Certified . . . regardless of the time of year!*

Then, too, Walker-Gordon Certified is delivered fresher than ordinary milk. This, plus the cows' wonderfully balanced diet, makes its Vitamin C content higher . . . and gives it a much finer, richer taste.

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# Consider all 3 insulins for better diabetes control...

THE physician now has three types of insulin available to treat diabetes. One is quick-acting but short-lived. Another is slow-acting but long-lived. The new third one—'Wellcome' Globin Insulin with Zinc—is intermediate.

Action with Globin Insulin begins moderately quickly and persists for sixteen or more hours, sufficient to cover the period of maximum carbohydrate intake. By night, activity is sufficiently diminished so that the likelihood of nocturnal reactions is minimized. A single injection daily of 'Wellcome' Globin Insulin with Zinc will control the hyperglycemia of many diabetics. When a diabetic requires insulin therapy, the physician is wise to consider all *three* insulin types.

'Wellcome' Globin Insulin with Zinc is a clear solution, comparable to regular insulin in its freedom from allergenic properties.

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Perhaps you prefer to make your *own* test. Many doctors do. There is no better way to prove to your own satisfaction the superiority of PHILIP MORRIS.

* *Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154*
*Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60*

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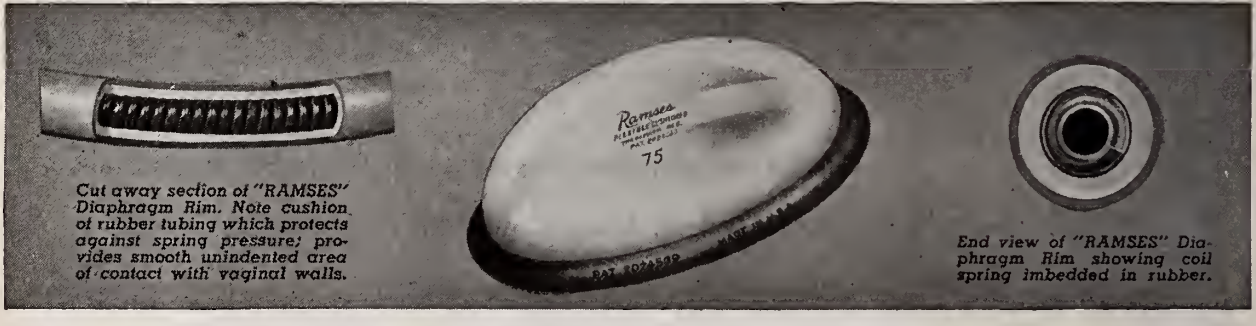
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The spring is covered with soft rubber tubing which serves to protect the patient against undue spring pressure. Also provides a wide unindented area of contact.




*Cut away section of "RAMSES" Diaphragm Rim. Note cushion of rubber tubing which protects against spring pressure; provides smooth unindented area of contact with vaginal walls.*

*End view of "RAMSES" Diaphragm Rim showing coil spring imbedded in rubber.*

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"RAMSES" Flexible Cushioned Diaphragms are supplied in sizes ranging from 50 to 95 millimeters. They are available through any recognized pharmacy. Only the "RAMSES" Diaphragm has the patented flexible cushioned rim.

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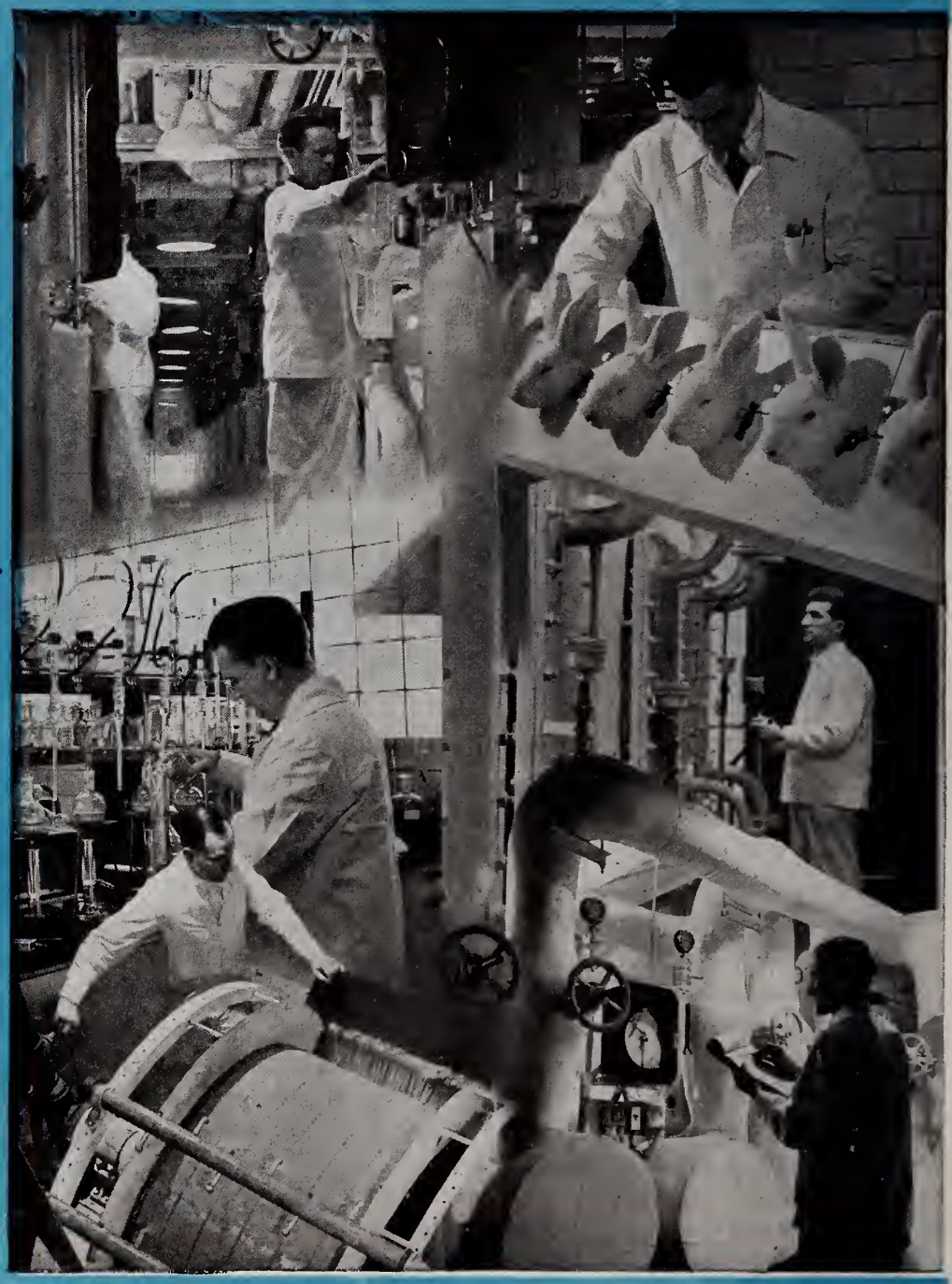
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**Non-elastic. Will not yield under strain. No leather, metal or hard pads.**



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*At left:*
Spencer Abdominal Supporting Belts designed especially for man and woman pictured. Non-elastic. Instantly adjusted. Can not yield or slip. The weight of support is placed on the pelvic girdle, not on spine at or above lumbar region.

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As a protection for the weakened abdominal wall, especially when patient is forced to return to work sooner than the doctor desires, a Spencer is helpful. Each Spencer is so designed as to permit exercise of abdominal muscles while providing adequate back and abdominal support.

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A powdered, modified milk product especially prepared for infant feeding, made from tuberculin tested cow's milk (casein modified) from which part of the butterfat is removed and to which has been added lactose, olive oil, coconut oil, corn oil, and fish liver oil concentrate.

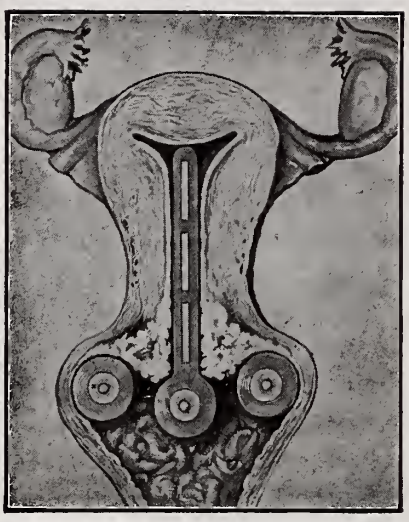
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Similac provides breast milk proportions of fat, protein, carbohydrate and minerals, in forms that are physically and metabolically suited to the infant's requirements. Similac dependably nourishes — *from birth until weaning.*

*One* level tablespoon of Similac powder added to *two* ounces of water makes *two* fluid ounces of Similac. This is the normal mixture and the caloric value is approximately 20 calories per fluid ounce.

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*"During pregnancy the average normal woman gains approximately 18-22 pounds, which represents the growth of the uterus, breasts and other organs as well as the fetus and placenta. In other words, a pregnant woman in nine months reproduces tissue almost equivalent to one-fifth of her own normal body weight. It must not be forgotten that the chief function of protein is to supply the tissue-building material of the body, that the need for this material is increased during pregnancy and that the protein deficiency in the diet of the nonpregnant woman may become dangerous when maternity intervenes. . . . It is reasonable to assume that protein foods satisfy appetite earlier than the others and make it content with fewer calories. In this respect we have found high protein diets of value for weight restriction during pregnancy." (Arnell, R. E.; Guerriero, W. F.; Goldman, D. W.; Huckeby, E., and Lutz, A. M.: PROTEIN MALNUTRITION IN PREGNANCY, New Orleans M. & S. J. 95:114 [Sept.] 1942).

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671

# ACIDOLATE

**FOR CONDITIONS BENEFITED BY A SOAPLESS REGIMEN**

# Penicillin DOSAGE TABLE*

| INDICATIONS | INITIAL DOSE (UNITS) | CONTINUING DOSAGE (UNITS) | UNITS IN 24 HR. | REMARKS |
|---|---|---|---|---|
| ***Serious Infections*** (staphylococcus, clostridium, hemolytic streptococcus, anaerobic streptococcus, pneumococcus, gonococcus, anthrax, meningococcus)<br>Adults and children | 15,000 to 20,000 | (a) Intravenous drip: 2000 to 5000 every hr. | 40,000 to 120,000 or more | (a) Dissolve ½ of 24 hr. dose in 1 liter (1000 cc.) normal saline; let drip at 30 to 40 drops per minute. |
| | | or<br>(b) Intramuscularly: 10,000 to 20,000 every 3 or 4 hr. | 40,000 to 120,000 or more | (b) Concentration: 5000 U. per cc. normal saline. |
| | | or<br>(c) Intramuscular drip | 40,000 to 120,000 or more | (c) Total daily dose in 250 cc. normal saline. |
| Infants | 5000 to 10,000 | 3000 to 10,000 intramuscularly every 3 hr. | 20,000 to 40,000 or more | Each dose in 1 or 2 cc. of normal saline. |
| ***Chronically infected*** compound injuries, osteomyelitis, etc.<br>Adults and children | 5000 to 10,000 | 10,000 every 2 hr. or 20,000 every 4 hr. intramuscularly or intravenously. Larger doses may be necessary at times. | 40,000 to 120,000 or more | Concentration for intramuscular inj.: 5000 U. per cc. normal saline.<br>For intravenous inj.: 1000 to 5000 U. per cc.<br>Supplement with local treatment. |
| ***Gonorrhea*** | 20,000 every 3 hr. intramuscularly for 5 doses | | 100,000 | Results of treatment should be controlled by culture of exudate. |
| ***Empyema***<br>Adults and children | 30,000 to 40,000 once or twice daily into empyema cavity | | 30,000 to 80,000 | Dissolve in 20 to 40 cc. normal saline and inject into empyema cavity after aspiration of pus. |
| ***Meningitis***<br>Adults and children | 10,000 once or twice daily into subarachnoid space or intracisternally | | 10,000 to 20,000 | Concentration: 1000 U. per cc. normal saline. |
| ***Bacterial Endocarditis***<br>Adults and children | 25,000 to 40,000 | 25,000 to 40,000 every 3 hr. intramuscularly | 200,000 to 300,000 | Continuous treatment for 3 weeks or longer. In a few cases the intravenous drip is more advantageous. |

*Based upon recommendations by Chester S. Keefer, *War Production Board Penicillin Leaflet*, Apr. 1, 1945; and by Wallace E. Herrell and Roger L. J. Kennedy, *Journal of Pediatrics*, 25:505, Dec., 1944.

● *Write for pocket size copies of this Dosage Table*

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Number 7



# THE JOURNAL
OF
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## EDITORIALS

### INAUGURAL ADDRESS

**Samuel Alexander, M.D., President**

To thank The Medical Society of New Jersey for the great honor which has just been bestowed upon me is very difficult to express through words. I appreciate it, and realizing the importance of the work to be done, assure you that I will give the position all the time and energy at my command.

Mingled with my feelings of humility and gratitude is the strong sense that there have been few times when energetic planning and leadership have been more necessary than they are today. We are living in a changing era, accentuated by war, and must acknowledge that people are disturbed and interested in the adequate distribution of good medical service on a high professional plane, at a price which they can afford to pay. If changes in the present practice of medicine are found necessary, they should be brought about upon an evolutionary basis, founded on scientific study and not by abrupt revolution by panacea proponents. I am anxious that the experimental stages of the Medical-Surgical Plan will have been passed before this year is over. When this point has been reached, this plan can be made available to the mass of employed persons in our State with full confidence of acceptance on their part. All progress in this field to date has been most encouraging. Coupled with the Medical Administration Plan and the Newark Plan for the Indigent Sick, a system is being evolved which will assure adequate medical care in any part of the State under the sound professional guidance of the physicians.

A progressive public relations program is of the utmost importance to organized medicine to better acquaint the people of our State with the purposes and programs of our Medical Society. In so many of the problems affecting public and private health we have not assumed the leadership that is rightfully ours. The recent cancer campaign was largely instituted and promulgated by lay groups. Although we took a small part in that

campaign, I feel that we should have been a leader and prime mover in its successful integration. The same feature pertains to pneumonia, tuberculosis, penicillin and the other innumerable problems arising each day in which an enlightened population expects the physicians of the State to act as standard bearers for truth and accurate scientific guidance. It is not enough that we prepare and perfect our plans for the adequate distribution of medical care to all peoples, but it is essential that these programs be fully presented to an ever more interested public.

I feel that a great amount of work will be done this year through the medium of our Welfare Committee. Under the able leadership of Dr. Sigurd Johnsen and with the skillful assistance of the chairmen and members of the various subcommittees, I am confident that real effective forward movement will be realized during the year 1945-1946. I have asked that the Chairman of the Welfare Committee and the Chairman of the Public Relations Committee be invited to attend all meetings of the Board of Trustees to the end that a closer coördination of their joint efforts may be effected.

While not unmindful of the major war effort in which we are engaged in the Pacific, this year will see many of our doctors in the Army released to civilian life. Proud of their contributions in all phases of global war, we must accept certain responsibilities in aiding their return and readjustment to private practice. In many instances, war has left its marks upon them, and in others their viewpoints have changed and broadened since they went away. As these men come back our first obligation is to assist and encourage them in their return to private practice. While we can not foresee exactly what their needs will be, we must make every effort to meet whatsoever reasonable requirements that do develop. We must do everything within our power to smooth their transition and help them, to assure them that their hospital appointments are at least as good as they were when they entered service, to see that they have not lost seniority, to help them in building up their private practice with deeds more than words and to see that the practice of medicine for them is at least what it was, if not better, than when they went away. These things we, as an organized group working in harmony, can do for our fellow physicians returning from service with the Armed Forces.

I am anxious that our Legislative Committee continue its excellent work, and to do this it must have the complete coöperation of all of our members. This committee, it will be remembered, has not only the task of seeing that good public health legislation is enacted into law, but also that of always being on the alert to see that bad or obnoxious legislation inimical to the health of our people be not enacted into law.

I hope to have a uniform intern training program developed in conjunction with the State Board of Medical Examiners for the guidance of the hospitals of our State. It is in the interest of the public good that interns trained in our State be ever better prepared to treat the sick when they start the private practice of medicine. In the same vein, I am hopeful that the Committee on Post-Graduate Education will bring to a successful conclusion its efforts to make available in New Jersey graduate medical studies for our physicians.

I believe that we should give every encouragement to the Woman's Auxiliary of our Society. They fill a most useful need in our program, and it should be recognized that in many aspects of statewide activity the women can do even better work than our own members. We shall avail ourselves of the services of these talented women and I know medicine shall profit thereby.

I will not go into further detail at this

time of the other things I think should be done, but I will communicate with you from time to time through *The Journal* concerning matters I think organized medicine should accomplish throughout this year. I pledge you that I shall apply what ability I may possess in the best interest of the doctors of the State. I ask only that the doctors and the office staff give me the same full coöperation and support that they have given in the past, and I shall look forward to an active, progressive year reflecting credit upon the physicians of the State of New Jersey.

## THE 1945 WAGNER-MURRAY-DINGELL BILL

In this issue (p. 209) will be found "Comments on the Public Health and Medical Aspects" of the Wagner Bill. This preliminary analysis with comments was prepared especially for the information of the New Jersey members of the Congress, and a printed copy, with a covering letter by President Alexander (p. 209), has already been sent to both of our Senators and to each of our Congressmen.

The first step in crystallizing the opinion of organized medicine of this State on the measure is for *every* member of the Society to write to either of our Senators, or the Congressman representing his district, for a copy of the Bill. The Senate Bill is S. 1050 and the House companion measure is H. R. 3293. It is obvious that an intelligent understanding by the individual physician of the proposals contained in the Bill, and their implications, can only be obtained by a careful study of the measure. In our opinion, a reading of this Bill, at least those sections concerned with medical practice and public health, should be a *must* for every member of our Society.

## DISTRIBUTION OF MEDICAL CARE

The reintroduction of the Wagner-Murray-Dingell Bill in slightly modified form to the National Legislature has aroused new and greater interest in the question of the distribution of medical care on the part of organized labor, social agencies, organized medical groups and the general public. Heated controversy will inevitably arise regarding the proposal to socialize medicine which the Wagner-Murray-Dingell Bill proposes. In order that we may be able to discuss this question intelligently, each of us should familiarize himself with the arguments against the socialization of medicine and with the position of The Medical Society of New Jersey in regard to the problem of the distribution of medical care. Our opposition to socialized medicine is not because of economic reasons, but because we believe that socialization of medicine will inevitably lead to deterioration in the standards of medical care. The care of the sick does not lend itself to mass production methods. The advocates of socialized medicine draw an analogy between teaching and medical practice. The analogy is inapplicable because while education in the fundamental branches of knowledge can readily be given in large groups, medical care must be individualized.

# STATE ACTIVITIES

## PRESIDENT'S LUNCHEON

On Wednesday, May 23, 1945, at the Hotel Claridge, Atlantic City, a luncheon was given by the Board of Trustees to the retiring President, Dr. Joseph F. Londrigan, Hoboken.

Dr. James F. Norton, Jersey City, Chairman of the Board of Trustees, was toastmaster at this occasion. In brief, Dr. Norton gave testimony of the accomplishments of Dr. Londrigan's administration. He pointed out the state-wide approval of the Medical-Surgical Plan of New Jersey, brought about by the untiring efforts of the President to obtain approval of the Plan in the final three counties which had previously withheld approval.

The purchase of the long desired permanent home of the State Society in Trenton is another of the highlights of Dr. Londrigan's year.

The institution of the Service Physicians' News Letter, a periodic communication to all our members in service, was largely through the efforts of our President. This Letter sends news from home to our service members and keeps them up-to-date on the activities of our Society and the whereabouts of their colleagues.

Dr. Londrigan had and still has a very deep, real and abiding interest in the changing philosophies so prevalent today and in wanting to bring the philosophy of organized medicine in line with the changing philosophies of the time. He was instrumental in effecting the approval of the National Physicians Committee by The Medical Society of New Jersey and the formation of the New Jersey Physicians Committee of which he was elected Chairman.

On behalf of the staff of St. Mary's Hospital, Hoboken, Dr. Hugh H. Tyndall, Weehawken, presented Dr. Londrigan with an order for an oil painting to be hung in the hospital in appreciation of his long service and loyalty to that institution.

An order for a hat was presented to Dr. Londrigan by the clinic staff through Dr. Eugene M. Kiely of St. Mary's Hospital, Hoboken, in appreciation of his unfailing interest in the younger physicians and the opportunities afforded them through his efforts.

In appreciation of the President's effort in behalf of our members in the Armed Forces, Dr. Londrigan's home County Society, Hudson, through Dr. Vincent P. Butler, Secretary, presented him with a brass plaque dedicating the permanent home of the State Society to the honor of our members who served in World Wars I and II; this plaque to be hung in the home at Trenton.




Greetings from the Medical Society of the State of New York were extended by Dr. Edward R. Cuniffe, President. Dr. Cuniffe, also Chairman of the Judicial Council of the American Medical Association, gave a brief sketch of the recent activities of the A. M. A. and the part the State Societies' can play in their ultimate accomplishment.

Junior Past-President of The Medical Society of New Jersey, Dr. Ralph K. Hollinshed, Westville, welcomed Dr. Londrigan into the ranks of the Fellows of the State Society and presented him with the Fellow's Key.

Dr. Londrigan responded and expressed his appreciation for the honors bestowed upon him. He thanked the Officers, Trustees, Committees and Staff of the State Society and County Societies for their coöperation during his administration, and pledged his continued coöperation and support in the activities of the Society.

Dr. Norton introduced the new Officers of the State Society to the audience—Dr. Samuel Alexander, Park Ridge, President; Dr. Frank G. Scammell, Trenton, President-Elect; Dr. Royal A. Schaaf, Newark, First Vice-President; and Dr. J. Howard Hornberger, Roebling, Second Vice-President.

## THE 1945 WAGNER-MURRAY-DINGELL BILL

The following letter and printed copy of "Comments" on the Wagner-Murray-Dingell Bill have been sent to all New Jersey Representatives in Congress and to both Senators:

Dear Congressman:

A request in a recent letter from Senator H. Alexander Smith, for our organization's reaction to the Wagner-Murray-Dingell Bill (S. 1050 and H. R. 3293), introduced in the Senate and in the House May 24th, leads me to believe that all the New Jersey members of the Congress might wish to know our opinion of this measure. Your attention is, therefore, respectfully invited to the enclosed "Comments on the Public Health and Medical Aspects of the Wagner-Murray-Dingell Bill."

We are limiting our comments at this time to the public health and medical aspects of the Bill because we feel, as a result of our training and experience, to be peculiarly qualified to express an opinion upon these features and their implications. While keenly interested, of course, as citizens, in all sections of the Bill, we have no special competence to voice opinion upon several of the projects proposed.

We hope, however, as the result of continuing intensive study of the Bill in its entirety, with appraisal of analyses made by qualified groups, to form opinion of some, at least, of the other features of the measure.

While in accord with the objectives sought by this Bill we are not in sympathy with the general philosophy of the measure. We share the composite view, as we understand it, of most of the New Jersey members of the Congress, as expressed to us after the introduction of the 1943 version of the Wagner-Murray-Dingell Bill:—That the universal application of the concept underlying this Bill (1) would seriously weaken the governments of the several states by the federal government abrogating and appropriating legitimate functions, duties and responsibilities of the states and their political sub-divisions, and (2) would weaken the character of the people by relieving them of practically *all* of their primary responsibilities.

If you feel inclined, we shall very much appreciate learning of your reaction to our comments on the public health and medical aspects of this Bill.

I am with respect,

Very sincerely yours,

SAMUEL ALEXANDER, M.D.,
President.

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## COMMENTS BY THE MEDICAL SOCIETY OF NEW JERSEY ON THE PUBLIC HEALTH AND MEDICAL ASPECTS OF THE 1945 WAGNER-MURRAY-DINGELL BILL

**(S. 1050 and H. R. 3293)**

*Prepared especially for the information of the New Jersey members of the Congress*

### TITLE VI
### GRANTS AND LOANS FOR HOSPITAL AND HEALTH CENTER CONSTRUCTION
(Pages 2 to 31)

PART A—SURVEYS AND PLANNING

Sec. 601-604, "Appropriations for Survey Grants to States"—pages 2-5

(a) It should not be necessary to grant federal funds to any state for the purpose of surveying their needs. Existing agencies within each state are already cognizant of the needs within their respective states or can determine them at very nominal costs.

(b) Extravagant surveys may tend to lead to unnecessary hospital construction and related facilities.

(c) We believe that hospital construction in any state should be fixed in accordance with an established ratio of bed capacity to population. No such provision is contained in the Bill.

(d) The need for additional hospitals and related facilities should be determined at a state, county or community level without the establishment of standards, restrictions or interference by a federal agency.

PART B—CONSTRUCTION OF HOSPITALS AND RELATED FACILITIES—Sec. 611-633—pages 5-31

(a) Under the provisions of this Bill the hospital construction "maintenance and operation" (lines 3-5, page 15) programs within the state to which a grant is made, would be placed under federal control: "an approved State plan

shall be required to be in accord and consistent with the need for hospital projects in such States as determined by surveys made by or under the direction of the Surgeon General" (lines 12-15, page 14). This would have the effect of tending to eliminate the control by state governments of matters pertaining to each respective state. It would tend to eliminate as part of our community life the spirit of the people of our communities to solve their problems in accordance with their local needs, which has become such an important factor in community life.

(b) It would organize a vast federal reconstruction program after the war under the control of the Federal Works Administration. (Sec. 615 [g] to [j], pages 18-19.)

(c) We note that the Bill provides for hospital facilities "without discrimination on account of race, creed or color" (lines 9-10, page 13). With this we are entirely in accord. However, in the same section (lines 10-14 incl.), it is stated that this provision shall not be effective where there are laws requiring separate facilities for separate population groups. Therefore, it amounts to nothing excepting in its political implications. It means, in our opinion, that in the southern states where racial segregation is practiced, this segregation will continue and that a lower standard will be maintained for the care of the Negro race, which will not meet the needs of the Negro.

(d) Federal assistance for hospital construction may be needed by certain states but in our opinion is not needed in the majority of states. We approve of federal assistance *only* where the need for federal aid is definitely established.

(e) Federal assistance should not be given to a state or non-profit organization for the construction of hospitals or related facilities without reasonable assurance that such hospitals or related facilities can be operated and maintained by the state or community. (See exceptions [4], page 15.)

(f) An adaptation of the formula for measuring the "financial resources" of the several states (Sec. 627, page 28) might be utilized in the determination of what states actually will need federal assistance for the construction of hospitals and related facilities.

## GRANTS TO STATES FOR PUBLIC HEALTH SERVICES

### (Sec. 4, Pages 32-42)

Sec. 4 amending Sec. 314 of the Public Health Service Act of July 1, 1944.

(a) We are entirely sympathetic with the broad objectives for "Public Health Services" envisaged by this Section.

(b) It is recognized that "public health services", to be effective, must be scientifically organized and administered by personnel adequately trained in the public health field; and that the program must be integrated within the state, and between states, if their fullest purposes are to be served.

(c) The splendid record of accomplishment, its excellent organization experience and the high level of professional competence of the personnel of the United States Public Health Service inclines us strongly to believe that integration of state programs with national "public health" plans will be productive of a more positive improvement in this vitally important branch of medicine than could be accomplished by the individual and uncoördinated efforts of the various states and other subdivisions of government with the several states.

(d) In some portions of this section ( [k], page 42) the term "public health" is designed to include "laboratory services". We believe such laboratory services as a public health service should be limited to those services necessary to the protection of the community as distinct from laboratory services necessary in the care of the individual sick person, which, in our opinion, should remain within the scope of function of the private practice of medicine. The same subsection includes "protection of health in maternity, infancy and childhood". We recommend the exclusion of the content quoted herein, as the same service is covered in this Bill under Sec. 501 and is not, in our opinion, a public health service. Beginning in line 13, page 42, we recommend the elimination of the words "medical and related services for prevention or mitigation of sickness or disability and for the prevention of prenatal death", because such phraseology includes the entire objective of the medical profession and could be interpreted as meaning all of the functions and responsibilities assumed by the private practitioner of medicine, and, furthermore, because provisions for these objectives are contained under Title II "National Social Insurance System" of this Bill. In line 16 of this subsection on page 42, we recommend the insertion of the word "public" before the word "health" so the phraseology will be "planning and coördination of *public health services*", and in line 18, after the word "regulations", the insertion of the words "for public health services". In line 21, the term "public health services" is designed not to include the construction of water supplies, sewerage and other waste-disposal systems. It is recognized that these facilities, which are the very basis

of proper community health, are vitally needed in many parts of our country.

## GRANTS TO STATES FOR MATERNAL AND CHILD HEALTH AND WELFARE SERVICES

(Sec. 501-502, Pages 43-56)

### PART 1—MATERNAL AND CHILD HEALTH SERVICES

Pages 43-45

(a) We are opposed to any increased appropriation for maternal and child health services as contemplated in Sec. 501 and 502. We are strongly convinced that it is fundamentally unsound to continue the expansion of these and various other similar services until and unless such services are brought under the jurisdiction of one department—a National Department of Health. Organized medicine in this state and throughout the nation for 70 years has advocated the creation of a National Department of Health headed by a physician with cabinet rank.

(b) Until such time as the above is effected we recommend the transfer of the maternal and child health services of the national government to the jurisdiction of the United States Public Health Service.

(c) In the State of New Jersey the improvement in maternal health is attributable to the activities of The Medical Society of New Jersey through its Committee on Maternal Welfare. This Committee, which has been operating since 1930, has established standards for obstetrical care and hospital practice including the investigation of every maternal death, which program has been responsible for the sharply decreased morbidity and mortality in maternal cases in this State.

(d) Through the coöperative efforts of the Children's Bureau of the State Department of Health in New Jersey and the medical profession in New Jersey, an impressive improvement in child health has been brought about during the past 25 years.

(e) As federal appropriations to the states for maternal and child welfare increase, the state appropriations decrease and the state assumes progressively less responsibility pertaining to the problems within the state. New Jersey does not need these appropriations, and it is entirely reasonable to assume that additional appropriations for increased activities in maternal and child health services would have been made by the state if federal appropriations had not been forthcoming for these purposes. If the present trend of expanding federal appropriations to the states for health services is continued it may not be long before the states will be relying entirely upon the federal government for *all* appropriations for these purposes. This is only one of several ways now in process to impose "State Medicine" (Federal Medicine) upon the citizenry of the state, one effect of which is to discourage incentive of communities to provide for their essentials at a community level to meet community needs as a voluntary community effort.

(f) Under the heading "Approval of State Plans" (Sec. 502(a), pages 43-44), a State plan for maternal and child health services to be approved must ( [8], lines 6-9, page 45) "provide that as services and facilities are furnished under the plan they *shall be available to all mothers and children in the State or locality who elect to participate in the benefits of the program.*" (Italics, ours.)

(g) We are opposed to the principle of furnishing curative medical services at federal expense for those able to pay for these services. Such services should be furnished without cost only to the indigent and those persons who at a local level of government are determined to be medically indigent.

### PART 2—SERVICES FOR CRIPPLED CHILDREN

Sec. 511, Pages 45-48

(a) This State has had for a number of years a well organized and adequately functioning "Crippled Children's Commission". New Jersey neither needs an appropriation from the Federal Government to carry on this program nor the "guidance" of the Chief of the Children's Bureau.

## TITLE XIII
## COMPREHENSIVE PUBLIC ASSISTANCE PROGRAM

(Pages 56-71)

Under this title provisions are made for federal grants to states for the support of approved plans giving general assistance to the needy.

As we interpret Title XIII, it does *not* provide a "comprehensive public assistance program". It is very specific in regards to benefits only for children under 18 years of age, and for persons over 65 years of age and the blind.

In our experience most indigent persons are between the ages of 18 years and 65 years, and many of them are unemployable, so that they would not be entitled to any benefits applicable to employed persons.

The following is a quotation, beginning on line 24, page 58, Section 1302.

"(A) eligibility for assistance will be

limited to one or more of the following: (i) individuals who have attained the age of sixty-five years (and if such individuals are included the plan must have no age requirements of more than sixty-five years), (ii) individuals who have not attained the age of eighteen years, (iii) blind individuals, or

"(B) there will be no age requirement which would exclude any individual who has not attained the age of eighteen years or who has attained the age of sixty-five years, and no disability or age requirement which would exclude any blind individual."

If our interpretation of this Title is correct it will not materially improve present plans and arrangements for the care of indigent persons, and is limited to assisting those persons who are already eligible for benefits under present social security legislation.

## TITLE II—NATIONAL SOCIAL INSURANCE SYSTEM—(Pages 71-185)

### A Brief Summary of Part A—Prepaid Personal Health Service Insurance (pages 71-106)

*Eligibility for Benefits*

Every employed person who is currently insured under the general provisions of the Bill, and his dependents (Sec. 201, page 71) are entitled to receive personal health service and hospital service benefits; including medical, dental, nursing, laboratory and hospital benefits.

The services are to be furnished by physicians, dentists or nurses operating individually or in groups, under such rules and regulations as may be prescribed by the Surgeon General of the United States Public Health Service, after consultation with the Social Security Board and the Advisory Council (Sec. 203 [f], page 74).

*The Advisory Council*—Sec. 204, page 77

The Advisory Council consists of 16 members appointed by the Surgeon General, "selected from panels of names submitted by the professional and other agencies and organizations concerned" with medical and allied services.

The Advisory Council has no authority and, as its name implies, its functions are entirely advisory (line 25, page 78).

The administrative authority is vested in the Surgeon General, "under the supervision and direction of the Federal Security Administrator, and after consultations with the Advisory Council." (Sec. 203 [a], p. 72.)

*Medical Service*—Sec. 205, page 80

All eligible persons are entitled to services of a "general medical or family practitioner" (page 84, line 5; page 83, line 3; page 82, line 5, etc.) and to specialist or consultant services "upon the advice" of the general practitioner, specialist or consultant "attending the individual", or "when requested by an individual . . . and approved by a *Medical Administrative Officer* appointed by the Surgeon General." (Italics, ours.) ( [d] page 81.)

"Specialist or consultant services shall be those so designated by the Surgeon General" and those "qualified as specialists or consultants . . . shall be those so designated by the Surgeon General" . . . (Sec. 205 [c], pages 80-81).

The Surgeon General has the authority to contract with hospitals for hospital services and the services of hospital *staffs* or *attending staffs* (Italics, ours) (Sec. 203 [c], pages 72-73, lines 8-10; page 84, lines 11-23, page 103).

Dental services (Sec. 210 [b], page 92) are limited to prophylaxis, x-ray, extractions, treatment of acute diseases and fractures.

Home nursing service is available upon advice of a participating physician or by approval of a "medical officer designated by the Surgeon General" (Sec. 205 [m], page 86).

*Selection of a Physician*

An eligible person may select a general practitioner from among practitioners "who have agreed to furnish services" and whose names are contained in a list published by the Surgeon General (Sec. 205 [e], pages 81-82).

The Surgeon General "may prescribe maximum limits to the number of potential beneficiaries for whom a practitioner or group of practitioners may undertake to furnish general medical or general dental benefit" (Sec. 205 [j], page 85).

*Payments to Practitioners*

General or family practitioners or general dental practitioners may be paid for their services. (Sec. 205 [g], page 83.)

1. On a fee for service basis
2. On a per capita basis
3. On a salary basis, whole or part time; or
4. On a combination or modification of these bases, as the Surgeon General may approve,

and (Sec. 203, page 73) by contracts between the Surgeon General and any state agency or private agencies or institutions and private persons or groups of persons (lines 3-11, page 73) "and to pay fair, reasonable, and equitable

compensation for such services" or by contracts between the Surgeon General and hospitals "to utilize inclusive services of hospitals *and their staffs* and/or *attending staffs*" (Italics, ours) (page 84, lines 8-10, and page 103, lines 11-23).

The patient, as may be determined by the Surgeon General, may be required to pay the physician a fee for the first service rendered during a period of sickness and the Surgeon General "may fix the maximum total amount of such fee payments in a period of sickness or course of treatment" (page 92, lines 6-7). "Such determination may also limit the application of such fees to home calls, to office visits or both" (page 92, lines 4-6).

*Participating Hospitals*

Participating hospitals shall be those designated by the Surgeon General (Sec. 206 [a] [b], pages 86 and 87).

Payments to hospitals shall be "Not less than $3.00 and not more than $7.00 for each day of hospitalization, not in excess of thirty days . . .; and not less than $1.50 and not more than $4.50 for each day in excess of thirty . . .; and not less than $1.50 and not more than $3.50 for each day of care in an institution for the care of the chronic sick."

## COMMENTS ON TITLE II

### PART A—PREPAID PERSONAL HEALTH SERVICE INSURANCE

1. With no other check than that of the Federal Security Administrator, the Surgeon General of the Public Health Service will control the disbursement of over three billion dollars per year.

2. By virtue of the provisions of the Bill and through rules and regulations which he is empowered to promulgate, the Surgeon General would control the practitioners of medicine and allied professions, and the practice of medicine.

3. The proponents of the Bill claim it assures freedom from political influence and that it is neither socialized medicine nor state medicine. It is impossible to reconcile such claims with the fact that the Bill does provide for the creation of a national compulsory sickness insurance system, centralized in our national government, and that payments are to be made from our national treasury for medical and hospital care rendered to employed persons.

4. The Bill further provides for the creation of the actual machinery and bureaucratic organization necessary for the political control of this vital service involving the health of the people.

5. This typifies the pattern of national socialism. Is the health of the individual so poor or the standard of health of this nation so low as to warrant the serious consideration of the revolutionary, socialistic program so far commented upon herein, proposed by this Bill?

6. The proponents contend that every patient will be allowed to choose his own physician, yet the Bill provides that the patient may only choose a general or family practitioner (what is a practitioner?) from among those who have agreed to participate in the system and who have not been chosen by too many other people in the opinion of the Surgeon General.

7. The patient does not have free choice of the physician who, he believes, is most competent to treat the medical condition as it affects the person in need of treatment.

8. Free choice of physician would be further inhibited by the regulations and restrictions imposed by the system when placed in practical operation.

9. The Bill provides that methods of administration shall "promote personal relationship between physician and patient". The actual operation of the system with its required reports, regulations and restrictions would in itself inevitably promote the opposite result.

10. The philosophy of Title II, Part A of the Bill is based on the thesis that by increasing the *quantity* of medical care the health of the people will be improved, whereas the experience of countries with similar systems of compulsory sickness insurance has demonstrated that when such *quantity* of medical care is substituted for *quality* of medical care the health of the people is adversely affected. This is particularly well demonstrated in the experience of Germany, Austria and Italy, where such systems have long been in effect. On the other hand by contrast the sickness and death rates in the United States are lower than those of any other large country in the world.

11. In countries having such systems, the standards of medical education, the standards of medical care, and the caliber of men entering the profession have deteriorated.

12. The high standards of medical care and health of our people have been attained through the continued efforts of the medical profession to improve medical education, and the application of the principles of free enterprise with its encouragement of the initiative of the individual physician as a member of a free society and of an independent medical profession.

13. Organized medicine recognizes certain defects in our present methods of distributing medical care and our studies have clearly indi-

cated to us the complexity of the problem. It is futile to expect improvement in the health of the individual or the nation by the rendering of good medical care unless this is paralleled by improvement of such essential health factors as proper housing, proper sanitary environments, proper nutrition, education and recreation.

14. The experience of the voluntary hospital insurance plans, which in a comparatively short period of time have enrolled seventeen million people throughout the country for protection against the cost of hospital services, has encouraged organized medicine in this country to sponsor a similar non-profit program on a voluntary insurance basis to provide for payment of physicians' services. Such programs have already been placed in operation by organized medicine in more than twenty states and the launching of similar plans is imminent in other states. Such a program, sponsored by The Medical Society of New Jersey, is now in operation on an evolutionary basis for the benefit of the people in New Jersey.

15. It is our confirmed belief that any plan or program for the improvement of medical care distribution payable by tax money should be on a state and community level and designed for the benefit of the indigent and medically indigent members of our population. Sound plans to meet this objective are, in our opinion, the greatest need.

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## MEETINGS OF THE BOARD OF TRUSTEES

A regular meeting of the Board of Trustees was held at 2:00 p. m. on Sunday, April 15, 1945, at the Executive Offices, Trenton.

Those present were: Dr. Norton, Chairman, who presided; Dr. Stahl, Dr. McBride, Dr. Hawkes, Dr. Londrigan, Dr. Alexander, Dr. Costello, Dr. Lee, Dr. Schaaf, Dr. North, Dr. Fithian and Dr. Hornberger. Also present upon invitation were Drs. Hollinshed, Scott and Barkhorn. Drs. Crowe, Young and Green were excused.

### Report of the President

1. *National Physicians Committee*

President Londrigan reported that a New Jersey Physicians Committee has been formed as the result of a dinner meeting given by the National Physicians Committee in Newark on February 28th, 1945. The New Jersey Physicians Committee now has a membership of about seventy-five, representing each County.

2. *Hospital Council, Inc., Representatives*

President Londrigan reported that in response to a request from the Hospital Council, Inc., for two representatives from the Medical Society to serve as members-at-large on the Council, he had designated for reappointment Dr. Henry C. Barkhorn and Dr. Royal A. Schaaf.

3. *Annual Meeting*

President Londrigan reported that all arrangements for the three-day Annual Meeting had been cancelled in conformity with the regulations issued by the O. D. T., but that he hoped to be able to hold a one-day meeting of the House of Delegates in Atlantic City.

Chairman Norton read a communication, dated April 11, 1945, from the Essex County Medical Society transmitting an action of the Council of the Essex County Medical Society requesting that the 1945 meeting of the House of Delegates be held in Newark.

Chairman Norton pointed out that the Board of Trustees, under the By-Laws, has authority to function for the Society between meetings of the House of Delegates. He felt, however, that if such a procedure were followed this year the Nominating Delegates should meet as usual and make their report to the Trustees.

President Londrigan suggested that legal opinion be obtained as to what the Board of Trustees could do at such a meeting, under the Constitution and By-Laws. It was also suggested that legal opinion be obtained as to whether the Nominating Committee has the right to meet at any time other than the evening of the first day of the Annual Meeting; there should be an interpretation as to whether the nominations would be legal under these conditions.

(The following opinion was received from our counsel, Mr. Albert Wall, on April 17th.)

"In my opinion there is no doubt of the Trustees' power to act. The generality of the language in Section 5(b) of the By-Laws confers the power, and when one considers the reason which lies behind the restriction imposed by the War Committee on Conventions, it is plain that you have every power except to hold a meeting in excess of the numbers that the restriction permits."

Dr. Hornberger moved that the Board of Trustees meet at the Claridge Hotel in Atlantic City on the evening of May 22nd and dur-

ing the day of May 23rd; that the members of the Nominating Committee of the State Society be notified that there will be a meeting of the Nominating Committee on the evening of May 22nd at 8 o'clock at the Claridge Hotel, and that the report of the Nominating Committee will be received by the Board of Trustees on May 23rd. If it becomes known that a full meeting of the House of Delegates can be held on May 23rd the County Societies and Delegates will be immediately notified. Seconded and unanimously carried.

Chairman Norton suggested that in communicating the above action to the County Societies the following statement preface the motion:

In view of the interdiction placed upon travel by the O. D. T., it is now thought to be impossible to have a meeting of the House of Delegates or any meeting of any group of the State Society in excess of fifty, and in order that the functions of the State Society shall proceed smoothly, and that the incoming administration shall have ample time in which to organize its activities for the coming year, the program outlined in the following resolution has been adopted as the most feasible.

Each County Society is to be fully informed of its obligations, adequately to discuss with its member of the Nominating Committee the importance of this meeting, and direct him to attend. At the completion of the deliberations of the Board of Trustees at the meeting in May a copy of its findings will be forwarded to each County Medical Society for ratification.

4. *Report of Insurance Committee*

President Londrigan reported that the Commercial Casualty Insurance Company had requested approval to offer its health and accident policies to the members of the County Medical Societies. The Medical Defense and Insurance Committee has met with this group and offers the following recommendation:

That the Committee on Medical Defense and Insurance is of the unanimous opinion that the group plan of accident and health insurance of the National Casualty Company is the most satisfactory contract at the present time, and its continuance is recommended to The Medical Society of New Jersey.

President Londrigan moved the above recommendation be adopted. Seconded and unanimously carried.

5. *Recommendations for Board of Health*

President Londrigan reported that he has submitted to the Governor the following recommendations for appointment to the Board of Health, preference in order listed, to fill the unexpired term of Dr. S. Josephine Baker, deceased:

Dr. Marcus W. Newcomb, Browns Mills
Dr. Thomas McG. Brennock, Jersey City
Dr. L. Samuel Sica, Trenton

It was moved, seconded and unanimously carried that President Londrigan's action in submitting the above recommendations to the Governor be approved.

6. *Survey of Hospitals Under Hill-Burton Bill*

President Londrigan reported that he had written to Governor Edge recommending that the survey of hospitals, under the Hill-Burton Bill, S-191, be placed under the Board of Health as the sole agency to make this survey.

The matter has been referred to a subcommittee of the Post-War Economic Welfare Commission. Representatives of the Medical Society—Dr. Alexander, Dr. Quigley and Dr. Sica — appeared before this subcommittee, which is headed by Senator Stanger, and urged that the survey be placed under the Board of Health. A final decision has not yet been made.

7. *Resolution to Mr. J. J. Thomas*

President Londrigan urged that a resolution be transmitted to Mr. J. J. Thomas, thanking him for his efforts in our behalf in securing the present home of the Medical Society.

It was regularly moved, seconded and unanimously carried that the above suggestion be complied with.

## Audit Committee

Dr. McBride presented the following report of the Audit Committee which was endorsed:

The Audit Reports on the examination as to the condition of the Medical Service Administration of New Jersey as of June 30, 1944, and the Medical-Surgical Plan of New Jersey as of June 30, 1944, have been carefully examined and found to be in accordance with the provisions of the act creating the Medical Service Administration of New Jersey.

It is recommended that all checks drawn on the Medical Service Administration—corporate account, revolving account, and farm security fund account —have uniformity of signature.

Otherwise, the reports as presented are proper and correct and are approved by the Audit Committee.

## Resolutions on Death of Dr. Conaway

The following resolutions on the death of Dr. Walt P. Conaway were presented by the

Committee appointed for this purpose, and upon motion it was directed they be forwarded to Dr. Conaway's family and spread upon the minutes of this meeting.

The Medical Society of New Jersey records with profound sorrow the death of its colleague and friend, Dr. Walt P. Conaway, of Atlantic City. He was beloved by all who were privileged to know him.

Our Lord called Dr. Conaway to his eternal reward on January 12, 1945, after a fruitful life on earth richly spent as a physician. He was endowed with a fine constitution, a keen mind, a cheerful and kindly manner. He administered faithfully to countless grateful patients who will also miss and mourn him as do we his fellow physicians.

We, his affiliates of The Medical Society of New Jersey, were enriched by our association with him. His contributions to the Society were many and varied. He was its President in 1927 and 1928; he was a delegate to the American Medical Association for many years, likewise a member of the Board of Trustees for years, and also served on many of the important committees of the Society throughout the years. In all of his activities in the Society he contributed much that was useful and helpful. We will miss him greatly.

We sincerely mourn his passing from this life and his earthly cares. To his beloved family we offer our heartfelt sympathy.

### Report of Permanent Home Committee

Dr. North presented the following recommendations from the Permanent Home Committee:

1. Rental of third floor apartment—$65.00 per month.
2. Employment of caretaker at salary of $125.00 per month, plus living quarters in garage apartment.
3. Renovation of garage apartment and garage proper.
4. Painting outside house and garage.
5. Roof repair, which requires scaffolding.
6. Purchase of venetian blinds on first and second floors of main building.
7. Purchase of four fire extinguishers—basement and three floors of main building.
8. Repair of concrete in front of building.
9. Purchase of library shelving, cost not to exceed $300.00—for the library room on the second floor, to accommodate the medical history records of the Society, and such other material and books as may be on hand.

Two American flags at the entrance to the property have been presented to the Society by Dr. Scammell.

Dr. Hornberger moved that the report of the Permanent Home Committee be approved. Seconded and unanimously carried.

### Report of Finance and Budget Committee

Upon motion, seconded and unanimously carried the Trustees approved the action of the Chairman of the Finance and Budget Committee in sending flowers for the funeral of Commissioner William J. Ellis.

Dr. North reported that the Finance and Budget Committee had met today and reviewed the expenses of the Society for the current year and the requested budget for 1945-46.

### Inter-Professional Relationships Committee

Dr. Hollinshed, Chairman of the Committee on Inter-Professional Relationships, reported that the Committee had held one meeting since the last meeting of this Board. On March 18th the Committee met with the superintendents of hospitals throughout the State. The next step of the Committee will probably be to add to its membership one or two medical directors of hospitals and possibly one or two hospital administrators. The Committee will then attempt to formulate a policy which will be flexible enough to apply to any hospital in the state.

### Interne Training Committee

After a reading of the Committee's report, Dr. Alexander moved that the report be referred back to the Committee on Interne Training for further study, in view of the criticism that the State Board of Medical Examiners can not do anything to accomplish the objectives desired as the report suggests. Seconded and unanimously carried.

### Medical-Surgical Plan

Dr. Scott requested the appointment of a member to the Medical-Surgical Plan Board from the Fifth District to fill the vacancy created by the death of Dr. Theo. H. Boysen.

Dr. Scott presented a letter from the Michigan Medical Service relative to the organization of a Health Council along the lines of the Michigan Health Council recently created to bring complete health security to all the people of their state through private means and voluntary methods. The communication was addressed to the Medical-Surgical Plan and is referred by that body to the Board of Trustees of the Medical Society for its consideration.

### Report of Committee on X-Raying in Industry

Dr. Hornberger gave the following report of the Committee on X-raying in Industry:

We feel we should remind the Board of Trustees that this matter has great public health implications. It is therefore logical to assume that as governmental appropriation and control of public health measures assume greater proportions our feeling in this matter may have to be revised. We suggest therefore that the Medical Society continue to study this problem, to be alert, so as to be in a position to be a leader rather than to be led in the final analysis of this and other medical problems.

Mass x-ray of people in industry is a public health measure and as such should have the support and encouragement of the Medical Society. The technique of doing this work is a controversial issue.

Conditions vary in different parts of the State. It is our feeling that this work should be done:

1. By private physicians when personnel and equipment is available and requested.
2. By various county agencies where equipment and personnel is available and requested.
3. By the State Department of Health when requested by industry or the Medical Society of that particular County with their own equipment and personnel.

It was regularly moved, seconded and unanimously carried that the report be approved, and that the recommendations be forwarded to the Radiological Society, the Tuberculosis Association, the Department of Health and the County Societies.

## Recommendations from Welfare Committee

Dr. Hornberger presented the following recommendations from the Welfare Committee:

1. Social Security Campaign—June 11-15, 1945.

The Welfare Committee recommends to the Board of Trustees the appropriation of $2000-$2100 from the budget account of the Social Security Committee to cover the expenses of the campaign.

2. Legislation.

S-191 (Hill-Burton Bill) authorizes one hundred million dollars for hospital construction in the various states for the fiscal year ending June 30, 1946. The term "hospital" is defined in the Act as follows. "The term 'hospital' includes public health centers and general, tuberculosis, mental, chronic disease, and other types of hospitals, and related facilities, such as laboratories, out-patient departments, nurses' home and training facilities, and central service facilities operated in connection with hospitals, but shall not include any hospital furnishing primarily domiciliary care."

The Welfare Committee recommends that the bill be amended by substituting for the word "hospital" the phrase "public health facilities" and then define "public health facilities" to include hospitals and related facilities as set forth in the act, and that the recommendation for amendment be forwarded to the Board of Trustees of the American Medical Association and to its Bureau of Legal Medicine and Legislation.

3. Medical Practice.

The Medical Care of the Indigent and Low-Wage Group Committee recommends that each County Society in the State be contacted through the Executive Offices and be requested to supply the following information:

a. How are the indigent and low-wage group handled in your County from a medical standpoint?
b. How are the indigent chronic ill cared for?
c. How are the medically indigent cared for?
d. Is adequate medical care available for everybody?
e. What suggestions have you to offer for better medical care for the indigent sick and low-wage group?

Your committee strongly recommends a local government subsidy in the care of the above mentioned groups, but not State or Socialized Medicine in any form.

4. Public Health.

The Cancer Control Committee recommends that the Department of Health, Department of Institutions and Agencies, and the Medical Society integrate to provide supervision or a liaison between the various lay groups interested in single diseases where money is collected and spent for medical treatment and supervision.

The Mental Hygiene Committee recommends that the general hospitals be induced to develop and create a neuro-psychiatric department; add both indoor and outdoor services in this line of work which is seldom found in any general hospitals; and that training be made available to the younger medical men by special courses in our hospitals for mental diseases, in order that we may equip a sufficient number of medical men to adequately cover the work that is going to be necessary in this field.

Dr. Londrigan moved that the recommendations from the Welfare Committee be adopted, seconded by Dr. McBride and unanimously carried.

## Report of Committee on Uniform Code for Examination of Hospital Records

The Committee on Uniform Code for Examination of Hospital Records submitted a proposed bill relative to hospital records and the right of examination thereof, and a code of practice which have been adopted by the Committee on Medical Records of the New Jersey Hospital Association.

Dr. Schaaf moved that a copy of the proposed bill and the code of practice be forwarded to each member of the Board of Trustees for study and that action of the Board be deferred until the next meeting. Seconded and unanimously carried.

### Report of Committee on Private Hospitals

Dr. Lee reported that nothing further had been done in the investigation of private hospitals and future action will have to await the appointment of a new Commissioner of the Department of Institutions and Agencies.

### Social Security Committee

President Londrigan reported that the Social Security Committee would conduct, during the week of June 11-15, an educational campaign against political medicine. This campaign will take the form of public meetings in each Councilor District. All lay agencies will be invited to attend. A public relations agency will publicize each meeting and make the arrangements. Meetings will be held in Atlantic City, Camden, Trenton, Paterson and Newark. Mr. Stegen of the National Physicians Committee will be the speaker at each of these meetings.

A number of each of three pamphlets against the socialization and political control of medicine will be sent, within the next two weeks, to each member of the Society for distribution to his patients.

### Communications

Chairman Norton read the following communications:

1. Acknowledgment of flowers for Commissioner Ellis.

2. Acknowledgment of communication to Legislative Committee favoring mandatory legislation to cause white bread to be enriched in accordance with standards adopted by the Federal Food and Drug Administration, if and when such bill is introduced. (S-236 introduced March 23rd.)

3. Acknowledgment of communication to Board of Health indicating our opposition to curtailment of essential foods and supplies for the well-being of children—Board of Health concurs in our position.

4. Acknowledgment from Veterans Administration of our disapproval of formation of clinics for non-service connected disabilities of veterans. Veterans Administration stated that no such action is contemplated, and that the only cases eligible for treatment by the Administration are those veterans who have service connected disabilities.

5. Acknowledgment from Governor's secretary of communication withdrawing names previously submitted as candidates for Board of Medical Examiners.

6. Acknowledgment from Governor's secretary of communication containing recommendations for appointment to fill vacancy on Board of Health.

7. Acknowledgment from Governor of communcation containing recommendations for appointment to Board of Medical Examiners.

### Approval of January 8, 1945, Minutes

Dr. Hornberger moved that the minutes of the January 8, 1945, meeting of the Board of Trustees be approved. Seconded by Dr. Fithian and unanimously carried.

The meeting was adjourned upon motion at 4:45 p. m.

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The annual meeting of the Board of Trustees was held at 4:00 p. m., Tuesday, May 22, 1945, at the Claridge Hotel, Atlantic City.

Those present were: Dr. Norton, Chairman, who presided; Dr. Londrigan, Dr. Alexander, Dr. Costello, Dr. Hawkes, Dr. Lee, Dr. Young, Dr. North, Dr. Fithian, Dr. Schaaf, Dr. Coleman, Dr. Stahl, Dr. Scammell and Dr. Hornberger. Also present upon invitation were Dr. Hollinshed, Dr. Scott, Dr. Barkhorn and Dr. Lewis. Dr. Crowe was excused.

### Approval of April 15, 1945, Minutes

Dr. Coleman moved that the minutes of the April 15, 1945, meeting of the Board of Trustees be approved. Seconded by Dr. Stahl and unanimously carried.

### Report of the President

1. *Candidates for the Board of Health*

President Londrigan reported that at the request of the Governor's Office the names of three women physicians had been submitted to the Governor as candidates to fill the vacancy on the Board of Health, created by the death of Dr. S. Josephine Baker.

Dr. Martha W. Tyndall, Westfield
Dr. F. Muriel Ramsey, Millville
Dr. Clara C. Renner, Blawenburg

Dr. Lee moved that the above names, submitted by President Londrigan, be approved. Seconded by Dr. Costello and unanimously carried.

The following candidates were also submitted to the Governor for appointment to the Board of Health, to succeed Dr. Martin H. Collier, whose term will expire July 1, 1945:

Dr. Martin H. Collier, Camden
Dr. Marcus W. Newcomb, Browns Mills
Dr. Arthur B. Peacock, Columbus

Dr. Coleman moved that the above names, submitted by President Londrigan, be approved. Seconded and unanimously carried.

(Governor Edge has appointed Dr. Martha W. Tyndall to succeed Dr. Baker, and Dr. Arthur B. Peacock to succeed Dr. Collier.)

2. *Representatives on Workmen's Compensation Advisory Committee of Department of Labor*

President Londrigan reported that in compliance with a request from Commissioner of Labor Harry C. Harper for the appointment of two representatives from the Medical Society to serve on the Workmen's Compensation Advisory Committee being set up by the Department of Labor, he had submitted the names of Dr. William K. Harryman and Dr. William F. Costello.

Dr. Stahl moved that President Londrigan's action in submitting the names of Dr. Harryman and Dr. Costello as representatives on the Workmen's Compensation Advisory Committee of the Department of Labor be approved. Seconded and unanimously carried.

3. *Recommendation of Michigan Medical Society*

President Londrigan reported that he had attended a meeting of seventeen State Presidents, called by the Michigan Medical Society, to discuss the sponsoring of radio programs in each of these states. Michigan has such a radio program and attributes a great part of the success of the medical-surgical plan in that State to this educational program. Such an over-all program would cost about $72,000 for thirteen weeks—each state to pay its share of expenses. President Londrigan stated that at the conference he had been appointed a member of a committee which passed a resolution stating that we were unalterably opposed to anything that would interfere with the American Medical Association. The idea is to form a planning committee that could devise ways and means whereby such a radio program could be carried on. President Londrigan was of the opinion that any program of this type should be carried on in conjunction with the Council on Medical Service and Public Relations of the A. M. A.

Dr. Costello moved that the suggestion offered by the Michigan Medical Society be referred to the Council on Medical Service and Public Relations of the American Medical Association. Seconded by Dr. Lee and unanimously carried.

4. *Annual Meeting*

President Londrigan reported that in compliance with the action of this Board opinion had been obtained from Mr. Wall, counsel, to the effect that the Board of Trustees had every power to act since war time restrictions precluded holding a full meeting of the House of Delegates. Subsequently resolution was received from the Monmouth County Medical Society which questioned the constitutionality of the Trustees' action on April 15 and proposed that the membership of the House of Delegates be numerically reduced to come within the purview of the order promulgated by the War Committee on Conventions (50).

It was deemed advisable to obtain legal opinion on the proposal from Monmouth County, and, in view of the death of Mr. Wall, the matter was referred to Mr. John Bruther, attorney. Mr. Bruther concurred in Mr. Wall's opinion that the Board of Trustees had authority to act and stated that the Monmouth County suggestion was devoid of legal authority.

President Londrigan moved that the Board of Trustees approve the opinion presented by Mr. Bruther. Seconded by Dr. Costello and unanimously carried.

Subsequently action similar to that of Monmouth County was taken by the Union County Medical Society.

It was regularly moved, seconded and carried that a copy of Mr. Bruther's opinion be forwarded to the Monmouth and Union County Medical Societies.

### COMMITTEE ON INTER-PROFESSIONAL RELATIONSHIPS

Dr. Hollinshed, Chairman of the Committee on Inter-Professional Relationships, submitted the following report:

The Committee on Inter-Professional Relationships met today at 2:00 p. m. The Committee went over the minutes of the previous meetings and it was felt that sufficient progress had been made in the solution of the problem—that we had arrived at the place where we were now ready to present a plan to the Hospital Association of New Jersey. This plan is as follows:

a. It is agreed that pathology, anesthesiology, roentgenology and physical therapy are medical services and the practice of medicine.
b. That these specialties are so recognized.
c. That an equitable arrangement can be made between individual hospitals and the doctors who practice these four specialties, recognizing the above principle, whereby the hospital may bill for these services in the name of the person rendering the service. (This can be done by inserting the name on the regular billhead, i. e., instead of "x-ray" indicate "professional services of Dr. Blank, Radiologist".)
d. Until such time as a medical service plan, providing such facilities, is available there is no objection to the inclusion of these medical services in the Hospital Service Plan contract, as long as the principle of recognition and proper remuneration to these specialists is carried out.

It was felt that it would be unnecessary to enlarge the Committee further and that if the Board of Trustees approved the plan adopted by the Committee we would ask the Hospital Association to appoint a committee to meet with our Committee to go over this plan and get their approval and have the Hospital Association adopt the plan. When this is done we will be able to bring in a final report to the Board of Trustees.

Dr. Lee moved that the above report be approved and that the recommendation that the Hospital Association be requested to appoint a committee to meet with our Committee be concurred in. Seconded by Dr. Londrigan and unanimously carried.

### Committee on Uniform Code for Examination of Hospital Records

President Londrigan moved that the proposed bill relative to hospital records and the right of examination thereof, and a code of practice, presented at the April 15th meeting of this Board, be referred to the incoming administration. Seconded by Dr. Scammell and unanimously carried.

### A. M. A. Meeting

Dr. Stahl reported that he had received the following telegram from the American Medical Association:

War Committee on Conventions of Office of Defense Transportation in Washington has denied permission for meeting of the House of Delegates of the American Medical Association in July. Will attempt to secure permission for a meeting of the House at a later time. Please notify delegates to the American Medical Association of your Association.

Olin West.

Dr. Stahl moved that the Delegates to the A. M. A. be notified of the contents of the telegram received from Dr. West. Seconded and unanimously carried.

Dr. Londrigan moved that a copy of the telegram from the A. M. A. be forwarded to the Monmouth and Union County Medical Societies for their information. Seconded by Dr. Coleman and unanimously carried.

### Medical-Surgical Plan

Individual motions were made by Dr. Londrigan, seconded by Dr. Costello and unanimously carried, nominating the following for the Board of Trustees of Medical-Surgical Plan for the coming year:

Dr. Samuel A. Cosgrove, Jersey City
Dr. Harry N. Comando, Newark
Dr. William E. Dodd, Ocean City
Dr. William K. Harryman, Hackensack
Dr. Augustus S. Knight, Far Hills
Dr. Thomas K. Lewis, Camden
Dr. Royal A. Schaaf, Newark
Dr. Norman M. Scott, Newark
Dr. Edward W. Sprague, Newark
Mr. John S. Thompson, Newark
Dr. David B. Allman (representing Fifth District), Atlantic City

Dr. Schaaf moved that Medical-Surgical Plan be authorized to publish, in the name of The Medical Society of New Jersey, a supplemental pamphlet which would incorporate the philosophical aspects of the Plan, which are not now permitted to be published in the present pamphlet of Medical-Surgical Plan. Seconded by Dr. Londrigan and unanimously carried.

### Communication from Middlesex County Medical Society

Dr. Fithian presented the following motion from the Middlesex County Medical Society:

A motion was moved and carried that Dr. George W. Fithian contact the representatives of the Rahway and the Perth Amboy Hospital Plans, so that he may present to the Board of Trustees of The Medical Society of New Jersey our recommendation that the Rahway and the Perth Amboy Plans be accepted by the Medical-Surgical Plan to act as its agent under the same conditions as now exist between the Medical-Surgical Plan and the Hospital Service Plan of New Jersey.

Dr. Costello moved that the communication from the Middlesex County Medical Society be referred to the Medical-Surgical Plan with the request that they contact the Middlesex and Union County Medical Societies and explain to them the mechanism by which they are working with the Hospital Service Plan. Seconded by Dr. Scammell and unanimously carried.

### Letter to Mr. Thompson

Dr. Lee moved that a letter of appreciation be sent by the Trustees to Mr. John S. Thompson for his gratuitous services in behalf of the Medical Service Administration and Medical-Surgical Plan. Seconded by Dr. Londrigan and unanimously carried.

It was directed that President Londrigan draft the letter to be sent to Mr. Thompson.

### Resolutions on Death of Mr. Albert C. Wall

Dr. Stahl moved that suitable resolutions on the death of Mr. Albert C. Wall be drawn, to

be spread upon the minutes and sent to his family; the committee to draw such resolution to be appointed by the Chairman of the Board. Seconded and unanimously carried.

The meeting was adjourned at 5:30 p. m.

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The reorganization meeting of the Board of Trustees was held at 3:00 p. m., Wednesday, May 23, 1945, at the Claridge Hotel, Atlantic City.

Those present were: Dr. Norton, Dr. Young, Dr. Green, Dr. Stahl, Dr. Coleman, Dr. Costello, Dr. Scammell, Dr. Alexander, Dr. Schaaf, Dr. Hornberger, Dr. North, Dr. Lee and Dr. Londrigan. Also present was Dr. Barkhorn.

Upon motion, Dr. Frank G. Scammell was chosen temporary Chairman.

### Election of Chairman for 1945-46

Upon motion by Dr. Lee, seconded by Dr. Costello, Dr. James F. Norton was declared unanimously elected Chairman of the Board of Trustees for 1945-46.

### Election of Secretary for 1945-46

Upon motion by Dr. Londrigan, seconded by Dr. Costello, Dr. Aldrich C. Crowe was declared unanimously elected Secretary of the Board of Trustees for 1945-46.

### Representative on Finance and Budget Committee

Upon motion by Dr. Stahl, seconded by Dr. Costello, Dr. Harry R. North was declared unanimously elected as Trustee member of the Finance and Budget Committee for a term of six years.

### Appointments

*Editor*—Dr. Stahl moved that Dr. Henry A. Davidson be reappointed Editor of the *Journal* for one year (without salary) on leave with the A. U. S. Seconded by Dr. Londrigan and unanimously carried.

*Executive Assistant*—Dr. Londrigan moved that Dr. Norman M. Scott be reappointed Executive Assistant, for one year, on loan full time to the Medical Service Administration. Seconded by Dr. Costello and unanimously carried.

*Executive Secretary, Legislative Committee*—Dr. Alexander moved that Dr. Frederic J. Quigley be reappointed Executive Secretary to the Legislative Committee for one year at the same salary and expense arrangement as now pertains. Seconded by Dr. Londrigan and unanimously carried.

*Acting Executive Officer*—Dr. North moved that Mrs. Edith L. Madden be reappointed Acting Executive Officer for one year. Seconded by Dr. Londrigan and unanimously carried.

### Action of April 15th re Annual Meeting Rescinded

Dr. Schaaf moved that the action of this Board, taken on April 15th, relative to submitting the proceedings of the Trustees to the County Societies for ratification, be rescinded in view of the legal opinion to the effect that actions of the Board of Trustees, in lieu of the House of Delegates, are proper and binding on the County Societies. Seconded by Dr. Alexander and unanimously carried.

### Resignation of Dr. Hornberger as Trustee

Dr. J. Howard Hornberger submitted his resignation as a member of the Board of Trustees from the Fourth District, effective immediately.

Dr. Costello moved that Dr. Hornberger's resignation be accepted, seconded by Dr. Londrigan and unanimously carried.

### Election of Trustee

Dr. Hornberger nominated Dr. William E. Dodd of Beach Haven to fill the vacancy on the Board of Trustees from the Fourth District. Seconded by Dr. North.

Upon motion the nominations were closed and Dr. Schaaf moved that the Secretary cast a ballot declaring Dr. Dodd elected a Trustee from the Fourth District to fill the unexpired term of Dr. J. Howard Hornberger.

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A regular meeting of the Board of Trustees was held at 2:15 p. m., Sunday, June 24, 1945, at the Executive Offices, Trenton.

Those present were: Dr. Norton, Chairman, who presided; Dr. Lee, Dr. Alexander, Dr. Costello, Dr. Coleman, Dr. Dodd, Dr. Stahl, Dr. Green, Dr. Schaaf, Dr. Scammell, Dr. Crowe, Dr. North, Dr. Londrigan and Dr. Hornberger. Dr. Young and Dr. Fithian were excused. Also present upon invitation were Dr. Scott, Dr. Sica, Dr. Johnsen and Dr. Barkhorn.

Chairman Norton presented the new member of the Board from the Fourth District, Dr. William E. Dodd of Beach Haven.

### Approval of Minutes

Upon motion by Dr. Coleman, seconded by Dr. Stahl and unanimously carried, the minutes of the May 22, 1945, meeting of the Board of Trustees were approved.

Upon motion by Dr. Schaaf, seconded by Dr. Lee and unanimously carried, the minutes of the reorganization meeting, May 23, 1945, were approved.

### Report of the President

President Alexander announced that he had completed appointments to the Welfare Committee and that the first meeting had been held on June 10th. Meetings are planned for October, January and April, with a meeting of the Board of Trustees two weeks after each meeting of the Welfare Committee.

President Alexander asked that the Chairman of the Welfare Committee and the Chairman of the Public Relations Committee be invited to attend each meeting of the Board of Trustees.

Dr. Costello moved that the Chairmen of the Welfare and Public Relations Committees be extended an invitation to attend each meeting of the Board of Trustees. Seconded by Dr. Coleman and unanimously carried.

President Alexander reported that in accordance with the action of the Trustees on May 22nd the Hospital Association had been requested to appoint a committee to work with our Committee on Inter-Professional Relationships. A reply has been received from the Hospital Association and the following have been appointed:

Mr. F. Stanley Howe, Orange Memorial Hospital, Orange
Mr. I. E. Behrman, Newark Beth Israel Hospital, Newark
Mr. George Buck, Mercer Hospital, Trenton

President Alexander reported that a communication had been received from Dr. Mahaffey of the Department of Health, stating that the Bureau of Venereal Disease Control and the Bureau of Industrial Health have been developing a plan for venereal disease case-finding and control that would be fair and mutually profitable to both the management of industrial plants and their workers. A tentative draft has been prepared and the Department of Health would like to have our Society study the program and make any suggestions for improvement thought desirable. The Department would also like to add a note to the final pamphlet stating that the program has been reviewed, or approved by our Society. President Alexander stated that copies of the tentative draft have already been forwarded to the Chairman of our Venereal Disease Committee and the Chairman of our Committee on Industrial Health and Hygiene.

Dr. Costello moved that the matter be referred to the Chairman of the Welfare Committee, and the Chairmen of the Venereal Disease and Industrial Health and Hygiene Committees with power to act. Seconded by Dr. Lee and unanimously carried.

President Alexander reported that he had received a communication from the New Jersey Office of the National Foundation for Infantile Paralysis, requesting approval by The Medical Society of New Jersey of a program for making a survey of the number of cases of poliomyelitis in the State.

Dr. Stahl moved that the Trustees approve the program for surveying poliomyelitis cases in the State, as outlined in the communication from the New Jersey Office of the National Foundation for Infantile Paralysis. Seconded by Dr. Lee and unanimously carried.

### Uniform Code for Examination of Hospital Records

President Alexander reported that he had referred the proposed bill for the examination of hospital records, and the code of practice, prepared by the New Jersey Hospital Association, to the Legislative Committee for opinion. The Legislative Committee has replied that the ideas embodied in the proposed bill have already been translated into law through the passage of Senate Bill 248, approved by the Governor May 2nd. The Committee feels that the code of practice has been well considered and prepared.

### Committee on Inter-Professional Relationships

Upon motion, seconded and unanimously carried, it was determined that the Committee on Inter-Professional Relationships be continued for another year.

Chairman Norton appointed the following members of the Committee:

Dr. Ralph K. Hollinshed, Chairman
Dr. Royal A. Schaaf
Dr. Frank G. Scammell
Dr. J. Howard Hornberger
Dr. Samuel Alexander, ex-officio

### Committee on Private Hospitals

Upon motion by Dr. Coleman, seconded by Dr. Lee and unanimously carried, it was determined that the Committee on Private Hospitals be continued for another year.

Chairman Norton appointed the following members of the Committee:

Dr. Thomas B. Lee, Chairman
Dr. William F. Costello
Dr. James H. Mason

### Committee on Interne Training

Upon motion by Dr. Londrigan, seconded by Dr. Costello and unanimously carried, it was determined that the Committee on Interne Training be continued for another year.

Dr. Londrigan moved that the personnel of the Committee remain the same as last year. Seconded and unanimously carried. The members are as follows:

Dr. Charles H. Schlichter, Chairman
Dr. John N. Connell
Dr. Henry B. Decker
Dr. Richard H. Dieffenbach
Dr. Arturo R. Casilli

### Communication from New Jersey Osteopathic Society

Chairman Norton read a communication from Dr. Francis A. Finnerty, President of the New Jersey Osteopathic Society, requesting comment from the Medical Society on the announcement of the "Graduate School of the Philadelphia College and Infirmary of Osteopathy" which proposes to open a hospital at Audubon, New Jersey, and "in view of a recent agreement" between the trustees of this organization and the trustees of the "Dearborn Medical College of Chicago" intends to grant the degree of Doctor of Medicine to student-physicians. The "Graduate School of the Philadelphia College and Infirmary of Osteopathy" is not connected in any way with the Philadelphia College of Osteopathy.

Dr. Costello moved that the Committee on Osteopathic Problems be reappointed and that this matter be referred to that Committee. Seconded and unanimously carried.

Chairman Norton appointed the following Committee and directed that the members select their own Chairman:

Dr. Samuel Alexander
Dr. Frank G. Scammell
Dr. Royal A. Schaaf
Dr. J. Howard Hornberger
Dr. Joseph F. Londrigan

The Committee elected Dr. Schaaf Chairman.

### Report of Welfare Committee

The recommendations from the June 10th meeting of the Welfare Committee, as presented by Dr. Johnsen, Chairman, were unanimously approved with the addition of a clarifying phrase to recommendation No. 2 of the Medical Practice Committee—"That the privileges of participation in hospital work be granted to qualified Negro physicians, *recognizing that final appointments rest with the administrative authorities of the hospitals.*"

### Post-Graduate Education

Dr. Decker, Chairman of the Post-Graduate Education Committee, appeared before the Board and reported that the Committee had met that day with representatives from Rutgers University, and that considerable progress had been made in working out a program for graduate training of physicians in New Jersey. Dr. Decker presented the representatives from Rutgers to the Board, and Dean Miller and Dr. Nelson spoke briefly to the members of their appreciation of the opportunity to work with the Medical Society in the establishment of a program for continuing the education of the physicians of New Jersey.

### Resolutions on the Death of Mr. Wall

Chairman Norton appointed the following committee to draw up resolutions on the death of Mr. Albert C. Wall:

Dr. E. Zeh Hawkes
Dr. Andrew F. McBride
Dr. Samuel Alexander

### Flowers to Mr. Joseph G. Buch

Upon motion by Dr. Londrigan, seconded and unanimously carried, approval was given to the action in sending flowers for the funeral of Mr. Joseph G. Buch, formerly Chairman of the Crippled Children's Commission, and more recently Director of the Rehabilitation Commission.

### Medical-Surgical Plan

Chairman Norton read a communication from the Medical-Surgical Plan, addressed to the Middlesex County Medical Society, as requested by this Board of Trustees, explaining the mechanism of the working agreement between Medical-Surgical Plan and the Hospital Service Plan of New Jersey, and the reasons for the inability of Medical-Surgical Plan to enter into a similar agreement with the Rahway and Perth Amboy Hospital Plans. (Copy on file in Executive Offices.)

Upon motion the communication was approved and placed on file.

A communication was received from Medical-Surgical Plant stating that Dr. William K. Harryman had submitted his resignation as a member of the Board of Trustees of the Plan, and that Dr. David B. Allman, nominated as a representative on the Board from the Fifth District, was unable to accept.

Upon motion by Dr. Alexander, seconded by Dr. Londrigan and unanimously carried, Dr. Rudolph C. Schretzmann of Rutherford was nominated to succeed Dr. Harryman.

Dr. Costello moved that the nomination of a representative on the Medical-Surgical Plan Board from the Fifth District be left to Chairman Norton with power to act. Seconded and unanimously carried.

### COMMUNICATION FROM WOMEN'S DIVISION, NEWARK SAFETY COUNCIL

Dr. Dodd, Chairman of the Advisory Committee to the Woman's Auxiliary, stated that the Women's Division of the Newark Safety Council is preparing a Baby safety folder for distribution to all mothers of small children through the Boards of Health, the hospitals and the P.-T. A.'s. The Council requests the approval of The Medical Society of New Jersey.

At a meeting of the Woman's Auxiliary to the State Society on June 19th it was recommended that the Advisory Committee to the Auxiliary obtain permission from the Board of Trustees for the Auxiliary to endorse the pamphlet, provided the contents meet with the approval of that Committee and the Committee on Child Health.

Dr. Dodd moved that the matter be referred to the Chairman of the Advisory Committee to the Woman's Auxiliary and the Chairman of the Advisory Committee on Child Health, with power to act. Seconded by Dr. Londrigan and unanimously carried.

The meeting was adjourned upon motion at 3:45 p. m.

ALDRICH C. CROWE, M.D.,
Secretary.

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## WELFARE MEETING

The organization meeting of the Welfare Committee was held at the Executive Offices, Trenton, Sunday, June 10, 1945.

### ATTENDANCE

Sigurd W. Johnsen, Chairman
Herschel S. Murphy, Vice-Chairman
Samuel Alexander, President, Ex-Officio

Atlantic—David B. Allman, D. Ward Scanlan
Bergen—Harrison B. Wilson
Burlington—S. Emlen Stokes
Camden—Henry B. Decker, H. Wesley Jack
Cumberland—H. Burton Walker, Albert B. Kump
Essex—Harrold A. Murray, H. Roy Van Ness, Harry N. Comando, William D. Crecca, Marcus H. Greifinger, J. Wallace Hurff
Gloucester—Wendell J. Burkett, Chester I. Ulmer
Hudson—Reeve L. Ballinger
Mercer—Walter E. D'Arcy, D. Leo Haggerty, L. Samuel Sica
Middlesex—William C. Wilentz, Ralph J. Faulkingham
Monmouth—Thomas H. Andrews, Stanley Nichols
Morris—Stanley Teskey, Daniel W. Teller, Jr.
Ocean—William E. Dodd
Passaic—H. Hale Hollingsworth
Salem—Harry F. Suter
Somerset—Frank L. Field
Sussex—Martin I. Kirschner
Union—Frederic W. Lathrop
Warren—William H. Varney
Consultants—Frederic J. Quigley, Mr. William H. MacDonald, Mr. John J. Debus
Guests—Walter B. Mount, Joseph F. Londrigan, Frank G. Scammell, J. Mallory Carlisle, Norman M. Scott, Samuel Blaugrund, Arthur P. Hasking, A. Charles Zehnder, H. Eugene Reading, James O. Hill, Theodore R. Robie, Julius Levy, Abraham E. Jaffin

President Alexander welcomed the members and guests and thanked them for accepting their appointments on the various committees and for attending this first meeting in such large number.

For the information of all, Dr. Alexander read from the Constitution and By-Laws of the State Society, Chapter VIII, Section 10, which outlines the duties and functions of the Welfare Committee.

Dr. Alexander stressed the importance of public relations in organized medicine; also the problem of organized interne training and the question of the returning soldiers.

Chairman Johnsen, in a short address, expressed his appreciation for such a large attendance. He stressed the threat of national compulsory health insurance, which, to defeat, will require a united front of all medical societies and organizations who are with us in this fight. Although we have restored a better working relation with our parent organization, the American Medical Association, and through its newly formed Council on Medical Service and Public Relations, in addition to the National Physicians Committee, all of which will give us valuable assistance, we still lack interest on the part of many of our members who fail to see the vital threat to the profession in this issue.

A brief review of past accomplishments of the various committees and programs of the Society was outlined by Dr. Johnsen, who stated, these accomplishments belie the statement that we as a profession are behind the times and have done nothing to meet the chal-

lenge of today. Misrepresentation or ignorance on the part of certain groups have belabored our public with these misrepresentations.

In conclusion, Dr. Johnsen urged unity in continued efforts to ensure that our system of free, independent and private practice of medicine shall continue.

Dr. Londrigan briefly reviewed the arrangements for the Health Forums to be held throughout New Jersey during the week of June 11-15, and urged the physicians to publicize the forums and urge people to attend.

### WAGNER-MURRAY-DINGELL BILL—S. 1050—H. R. 3293

Dr. Quigley gave a brief analysis of the new Wagner-Murray bill introduced on May 24 in the Senate and the identical bill introduced by Mr. Dingell in the House. It was suggested that each member write to his Congressman or Senator and request a copy of the bill.

Reference was made to the detailed analysis of the health features of the bill contained in the June 2 issue of the A. M. A. Journal. Subsequent Journals will contain further analyses of other portions of the bill.

A complete analysis is printed on page 209 of this Journal.

### DISTRIBUTION OF MINUTES

Upon motion by Dr. Stokes, second by Dr. Sica and unanimously carried, the Secretary was instructed to send a mimeographed abstract of minutes of Welfare meetings to each member to aid him in reporting what has transpired to his County Society.

It was suggested that a full copy of Dr. Johnsen's remarks at this meeting be sent to each member.

### MEDICAL PRACTICE

Chairman Wilson reported on the morning meeting of his Committee. At the invitation of the Committee three members of the New Jersey State Medical Association, an association of 128 Negro physicians in New Jersey, appeared before the Committee. As a minority group in our population they feel they do not have sufficient opportunity to practice medicine in the hospitals in New Jersey and there has been some discrimination against them in becoming members of county medical societies.

The following conclusions were reached after a lengthy discussion:

1. That Negro physicians throughout the state make application for membership in their respective county societies.

2. That the privileges of participation in hospital work and staffs be granted to qualified Negro physicians.

3. That in like manner the New Jersey State Medical Association direct its problems also to the New Jersey Hospital Association as it did to our body.

The Committee recommends to the Welfare Committee that the New Jersey State Medical Association be notified of these recommendations if they are adopted by our Society.

Dr. Wilson moved the adoption of the above recommendation, second by Dr. Ulmer. After discussion the motion was unanimously carried.

### LEGISLATION

Dr. Burkett, Vice-Chairman, reported in the absence of Dr. Pollak, Chairman. The morning meeting resolved itself after discussion with four facts:

1. That a full analysis of the Wagner-Murray Bill be made by Drs. Quigley and Scott.

2. That after a digest of the entire bill they prepare a brief.

3. That the Chairmen of the Welfare and Subcommittees be empowered by the Welfare Committee to approve this brief with such changes as they deem proper.

4. That the brief be presented to the Trustees for approval, after which it be sent to each New Jersey Senator and Congressman.

Dr. Burkett moved that the above recommendations be concurred in by the Welfare Committee. Second by Dr. Haggerty.

Dr. Allman suggested a fifth recommendation which was accepted by Dr. Burkett and Dr. Haggerty.

5. That the brief be sent to the Chairman of each County Society Legislative Committee.

The recommendations were unanimously approved.

The Committee received a request from the New Jersey Guild of Opticians to prepare a bill to qualify them by examination conducted by the State Board of Medical Examiners. The request was referred to Dr. Hurff who will make a report at the next meeting.

A letter from Dr. Finnerty, Chairman of the Legislative Committee of the New Jersey Osteopathic Society, relative to a new school of osteopathy in Philadelphia known as The Graduate School of the Philadelphia College and Infirmary of Osteopathy, who desire to open a hospital in Audubon, and in connection with the Dearborn Medical College of Chicago hope to be able to confer the degree of M.D.,

will be referred to the Board of Trustees for action.

The Committee considered a communication from an Army Captain who hopes to settle in New Jersey but has only one year pre-medical work. He has the necessary qualifications otherwise and is licensed in New York and Pennsylvania. The Committee felt that nothing should be done to change the Medical Practice Act at the present time and that the State Board, in refusing the Captain a license, is only carrying out the provisions of the Act which requires two years pre-medical work.

Upon motion by Dr. Mount, second by Dr. Ulmer, it was unanimously carried that any changes that are made in the Medical Practice Act should be forwarded to the office of every Class A medical school by the Secretary of the State Board of Medical Examiners.

## Public Health

Dr. Nichols, Chairman, reported that seven of the ten public health advisory committees will only meet when necessary. The other three have internal problems:

1. Cancer Control—to work in close contact with the New Jersey Cancer Society.
2. Tropical Diseases—to publish a supplement to last year's pamphlet in coöperation with the State Department of Health, which urges the control of the anopheles mosquito in each county, and with other groups.
3. Mental Hygiene—to provide good psychiatric education of every physician in New Jersey through the hospitals and county societies to provide good medical care through private practice to the returning soldiers, especially those with the NS classification.

Three external problems which affect the Public Health Committee are:

1. The Wagner-Murray-Dingell Bill.
2. The reorganization of the State Department of Health, upon which bill depends the private and public record of our doctors for years to come.
3. A Public Relations Bureau in the State Society with a good medical and executive staff who can do a good job for us.

Upon motion, regularly seconded and carried, the above report was unanimously adopted.

## Public Relations

Chairman Sica reported that his Committee is composed of the Vice-Chairmen of the Welfare and other three subcommittees, a member of the Board of Trustees and one member at large.

At the morning meeting, in accordance with the wishes of the Board of Trustees, two of the three members from a special committee of the Trustees met with the Committee to formulate a public relations policy for the State Society. The following policy was set up after a unanimous vote of those present that the Public Relations Committee should undertake an active program this year:

### Preamble

As in previous years, the objective of the Public Relations Committee is to secure and retain the good will of the people of New Jersey toward organized medicine in general and toward The Medical Society of New Jersey in particular.

We agree in principle with the nine points of the Platform of the American Medical Association.

The Medical Society of New Jersey reaffirms its endorsement of the following principles; and restates its position clearly and unequivocally in regard to these principles:

1. That medical care should be made available to every man, woman and child in the United States.
2. That medical care be made available to every person in New Jersey at a cost within his ability to pay.
3. That voluntary health insurance plans be made available to people of moderate income in catastrophic illnesses.
4. That the expenses of medical care of the indigent and medically indigent be defrayed by tax subsidy, retaining the free choice of physician for the patient and individual payment for medical service.

We point out that The Medical Society of New Jersey has already organized the Medical-Surgical Plan to help people in catastrophic illnesses and the Medical Service Administration to help solve the problem of medical care of the indigent and medically indigent.

We further declare our purpose to coöperate with all public and private agencies promoting health programs and our willingness and ability to assume leadership in such projects, and to coöperate with industrial and labor groups in an effort to attain our objectives.

In order to study and prepare a plan of operation for a public relations bureau, the Committee designated a group to act as an Executive Committee to report at the next meeting.

The Committee recommends the preparation, printing and distribution to all physicians and industries and other suitable places, a placard setting forth the principles of the Society regarding the distribution of medical care.

Upon motion by Dr. Sica, second by Dr. Murphy, the report was unanimously adopted.

Sigurd W. Johnsen, M.D.,
Chairman, Welfare Committee.

## STATE OF NEW JERSEY DEPARTMENT OF HEALTH

### PENICILLIN TREATMENT FOR SYPHILIS AND GONORRHEA

The New Jersey State Department of Health provides penicillin and/or hospitalization for the following types of patients:

1. Primary syphilis (chancre).
2. Secondary syphilis (rash, mucous patches, condyloma, etc.).
3. Latent syphilis *definitely* of less than one year duration.
4. Congenital syphilis under one year of age.
5. Gonorrhea in patients who either
   a. Are resistant to at least 20 grams of sulfonamide, or
   b. Are intolerant to sulfonamides, or
   c. Have serious, acute complications of the disease (epididymitis, ophthalmia, acute salpingitis, acute arthritis).

Penicillin is also provided for ambulatory treatment of the above types of gonorrhea in clinics and physicians' offices.

Certification must be made that the patient either:

1. Cannot afford to pay, or
2. Is under isolation imposed by the health officer under authority of law.

Application blanks and recommended schedules of treatment are available at most hospitals or from the State Health Department, Trenton. If difficulty is encountered in arranging for a hospital bed, the attending physician may either write to this Department or phone (Trenton 2-2131, Extension 704) for assistance.

Some patients may refuse treatment in a hospital near home because of fear that friends who are employees of the hospital will learn of their venereal infections. Such patients may be hospitalized in other cities where they are not known.

Penicillin treatment has a profound immediate effect upon syphilitic lesions and is effective in controlling infectiousness. However, this therapy, like all other rapid forms of treatment, interferes with the development of natural immunity. Thus, whereas reinfections after "standard" (arsenic-bismuth) treatment are infrequent, with penicillin treatment reinfections are relatively frequent unless the source of infection and exposed persons are found and treated. (With gonorrhea, reinfection has always been a problem.) Therefore, with penicillin treatment contact investigation is doubly important. Physicians are urged to arrange for *all* of their venereal disease patients (regardless of income, social standing, race or sex) to be interviewed for contacts by skilled investigators, specially trained and experienced in this work. These investigators are also trained and instructed in the protection of physician-patient relationship. For information as to the availability of this service in your local community write to your State Health Department. If, after using this service, you have any complaints or constructive suggestions, please tell us about them. Only in this way can a satisfactory coöperative relationship between physician and health department be maintained for the effective protection of the public health.

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## NUTRITION IN EVERYDAY PRACTICE

S. WILLIAM KALB, M.D., Newark, N. J.

Nutrition Representative, Tuberculosis and Adult Disease Control Advisory Committee to the Subcommittee on Public Health

1. What is the value of fruit as a dessert in the meal? Pineapple and papaya contain a protolytic enzyme, papain. This enzyme has strong digestive properties and may prevent dyspepsia. Other fruits contain mineral and vitamins and are important but not to the meal.
2. Do patients on reducing diets develop anemia? On the contrary, most obese patients have a secondary anemia which improves about 10 or 15 per cent after weight loss, providing they are on a high protein diet.
3. Is vitamin A useful in the treatment of acne? The dosage should be 100,000 units daily at bedtime for a period of one year. The acne may appear aggravated after the first few weeks of therapy but will gradually decrease as the intake of vitamin A continues.
4. Is the diet of the expectant mother respon-

sible for the presence of congenital malformation in the newborn? Many investigators have suspected this for a long time and have demonstrated that a diet low in vitamin A has produced calves born blind and pigs born in which some of the limbs were missing, some were born without eyeballs, some with harelip, cleft palate, accessory ears, and misplaced kidneys. Abnormality in skeletal growth was produced with diets deficient in riboflavin. The diet should have a sufficient amount of vitamin A and riboflavin.

5. Does vitamin B complex increase lactation? The administration of vitamin B complex during the antenatal period may bring about a better supply of milk because it helps to improve the general nutrition of the mother.
6. There is much talk of amino acids these days. What are the indications of its use? Amino acids will become important therapeutic aids and will be a must for their use in tissue repair. Tissue injury, whether from infections, burns, trauma, or major surgical procedures, is associated with nitrogen losses. To supplant these losses, the body protein is utilized and must be replaced. The oral intake of protein may be helpful but because of errors in digestion in some individuals, oral replacement is inadequate. Hence it is necessary to prescribe the proper amino acids for the production of plasma protein. Unfortunately most pharmaceutical houses have not put on the market as yet the essential amino acids for therapeutic use. However, Amigen by Mead Johnson & Company, is an enzymic digest of casein and pork pancreas and contains amino acids and polypeptides. Use parenterally one (1) gm. per kilogram of body weight of the patient.
7. Are vitamins of value in the treatment of shock? This condition is treated routinely with blood plasma or whole blood. However, the symptoms in shock produce a breakdown of several complex enzyme systems of the body, especially those containing B vitamins as a coenzyme. Hence, a sudden and severe vitamin deficiency occurs concomitantly with anoxia. Large doses of thiamine should be given in addition to blood replacing fluids. A high protein diet with thiamine should be given two weeks prior to operation as a prophylaxis against shock.
8. What is the cause of bed sores? Impairment of tissue resulting from protein deficiency, as well as local pressure, are the causative factors. With a controlled diet general improvement, increase in protein plasma, and healing of the bed sores follow.
9. Does tea have any stimulating properties? The alkaloid theine in tea is similar to caffeine and is a stimulant.

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## WITH NEW JERSEY MEDICAL AUTHORS

Compiled by Mildred V. Naylor, Librarian, Academy of Medicine of Northern New Jersey

It is requested that any New Jersey physician who publishes an article outside the state, notify the Editorial Office in Trenton, giving the title of the paper and the name of the periodical, as well as the month, date, volume and page number. It would also be helpful to this office if members would notify us of articles published by their colleagues.

Applebaum, Irving L.—Newark (In service)
Respiratory diseases in the tropics. J. Med. Soc. New Jersey 42: 111-113, Apr., 1945

Bechet, Paul E.—Elizabeth
Brief history of dermatology in New York City; its share in the progress of the specialty in America. New York State J. Med. 45: 629-633, Mar. 15, 1945

Ben-Asher, S.—Jersey City
Fatal reaction following the intravenous injection of mercupurin; review of the literature and report of a case in which a high environmental temperature was a contributing cause. J. Med. Soc. New Jersey 42:174-178, June, 1945

Berke, Raynold N.—Hackensack
Resection of the levator palpebrae muscle for ptosis, with anatomic studies. Arch. Ophthal. 33: 269-280, Apr., 1945

Brown, Evelyn L.—see VanSaun, Anna I.

Campbell, Meredith F.—Montclair
Present day treatment of nontuberculous renal infections. M. Clin. North America 29: 571-578, May, 1945

CARLISLE, JAMES M., and REX O. MCMORRIS—Rahway (Merck & Co.)
Physical medicine in industry. Arch. Phys. Med. 26: 353-358, June, 1945

CARPENTER, C. C.—Summit (in service) (with W. H. Hall, Jr.)
Treatment of dermatitis herpetiformis with penicillin. Arch. Derm. & Syph. 51: 241-42, Apr., 1945

CARRINGTON, WILLIAM J.—Atlantic City (in service)
Acute surgical diseases of female pelvis. J. A. M. A. 128: 434-437, June 9, 1945

CRUTCHFIELD, W. E., JR., Ph.B. of Med.—Rahway (Merck & Co.)
Improvement in nutrition as protection against industrial toxicity. Med. Woman's J. 52: 41-46, May, 1945

CUONO, JOSEPH D.—Paterson (in service)
Comments on casualties aboard assault cargo vessel. U. S. Nav. Med. Bull. 44: 1273, June, 1945

EISENSTODT, LESTER W.—Newark
Complete avulsion of the scalp; review of the literature and case report. Am. J. Surg. 68: 376-382, June, 1945

ERCOLI, N.; LEWIS, M. N., and HARKER, E. M.—Nutley
Antistaphylococcal activity of various sulfonamides, with a method for routine determination of chemotherapeutic activity. Am. J. Med. Sci. 209: 621-28, May, 1945

FINKLER, RITA S.—Newark
Primary amenorrhea of different origin. Med. Woman's J. 52: 37-38, Jan., 1945

FITZPATRICK, LEO J.—Ridgefield Park (in service) (with Paul C. Samson)
Intercostal nerve block; its rôle in the management of thoracic casualties. California M. & S. J. 62: 254-256, May, 1945

FRANKEL, EMIL—Trenton. Director of Division of Statistics, New Jersey State Department of Institutions and Agencies
Mental hygiene in New Jersey. J. Med. Soc. New Jersey 42: 107-10 Apr., 1945

FRIEDMAN, MILTON—Newark (in service)
Supervoltage (one million volt) roentgen therapy at Walter Reed General Hospital. S. Clin. North America 24: 1424-32, Dec., 1944

GOLDENBERG, RAPHAEL R.—Paterson
Closed manipulation for the reduction of fractures of the neck of the radius in children. J. Bone & Joint Surg. 27: 267-273, Apr., 1945

GOLDSTEIN, HYMAN I.—Camden
1. Wilhelm Konrad Roentgen—The centennial of his birth—semicentennial of the x-rays. J. A. M. A. 127: 1056-57, Apr. 21, 1945
2. Samuel Weiss, M.D., F.A.C.P., on his sixtieth birthday anniversary. Am. J. Digest. Dis. 12: 211-212, June, 1945

HARKER, E. M.—see Ercoli, N.

HUMMEL, E. G.—Camden
Hand-Schüller-Christian discase. J. Pediat. 26: 501-504, May, 1945

KALB, S. WILLIAM—Newark
Nutrition in everyday practice. J. Med. Soc. New Jersey 42: 187, June, 1945

KERN, E. CLARENCE—Montclair
Further evidence of the relationship between herpes zoster and varicella. J. Med. Soc. New Jersey 42: 179, June, 1945

KESSLER, HENRY H.—Newark (in service) (with G. B. O'Connor)
Plastic surgery of amputation stumps. U. S. Nav. M. Bull. 44: 1167-1180, June, 1945

KESSLER, HENRY H.—Newark (in service)
1. Definitive surgical management of amputations. U. S. Nav. M. Bull. 44: 1133-1148, June, 1945
2. Rehabilitation of the amputee. U. S. Nav. M. Bull. 44: 1196-1210, June, 1945

LEWIS, M. N.—see Ercoli, N.

MARKS, H. C.; WYSS, ORVILLE, and STRANDSKOV, FREDE B.—Belleville (Wallace & Tiernan)
Studies on the mode of action of compounds containing available chlorine. J. Bact. 49: 299-305, Mar., 1945

MARTLAND, HARRISON S.—Newark
1. Air embolism; fatal air embolism due to powder insufflators used in gynecological treatments. Am. J. Surg. 68: 164-69, May, 1945
2. Air embolism. Am. J. Surg. 68: 281-286, June, 1945

MCMORRIS, REX O.—see Carlisle, James M.

MILLER, RALPH, and JULIUS S. PERELMAN—Newark
Chronic auricular tachycardia with unusual response to change in posture. Am. Heart J. 29: 555-568, May, 1945

NICKMAN, EMANUEL H.—Atlantic City (in service) (with A. A. Goldbloom)
Penicillin versus sulfonamide therapy. M. Clin. North America 29: 579-589, May, 1945

OGDEN, M. A.—Passaic
Better test meal. J. Med. Soc. New Jersey 42: 180, June, 1945

ORTON, HENRY B.—Newark
Extra laryngeal surgical approach for arytenoidectomy: bilateral abductor paralysis of the larynx. Discussion. Ann. Otol., Rhin. & Laryng. 54: 214-15, Mar., 1945

OTNESS, H. ROBERT—Vineland (in service) (with Geo. A. W. Stouffer)
Naval offender; motivating factors. U. S. Nav. Med. Bull. 44: 1029-1035, May, 1945

PAUL, GEORGE A.—Irvington. Medical Director, Hyatt Bearings Division, General Motors Corp.
Program for the rehabilitation of the returning veteran. Safety Training Digest. 15-21, 1945

PERELMAN, JULIUS S.—see Miller, Ralph

POLOWE, DAVID—Paterson
New technic for reconstruction of the oviducts. Am. J. Surg. 68: 208-11, May, 1945

PRATT, ARTHUR G.—Camden (with Edward F. Corson)
Spread of dermatitis venenata by vesicle contents. Arch. Derm. & Syph. 51: 315, May, 1945

SATULSKY, E. M.—Elizabeth (in service)
Keratoderma blenorrhagicum: A brief review and report of a case treated with penicillin. Am. J. Syph. Gonor. & Ven. Dis. 29: 361-372, May, 1945

Schall, Elmer L.—Trenton (Bur. Industrial Health, N. J. State Dept. Health)
Safe handling of toxic materials and gases. Pub. Health News 27: 240-253, Apr., 1945

Strandskov, Frede B.—see Marks, H. C.

Talmage, William G.—Sucasunna (in service)
Acute benign pericarditis. Am. Heart J. 29: 623-627, May, 1945

Talmage, William G.—Sucasunna (in service) (with Roger W. Robinson)
Wolff-Parkinson-White syndrome. Am. Heart J. 29: 569-575, May, 1945

vanSaum, Anna I. and Brown, Evelyn, B.A.—Paterson
Rh factor and the public health laboratory. J. A. M. A. 128: 19, May 5, 1945

Wyss, Orville—see Marks, H. C.

# OBITUARIES

## DR. WILLIAM F. BENNETT

Dr. William F. Bennett, first assistant physician at Essex Mountain Sanatorium, Verona, for 18 years, died on May 2, 1945, at Mountainside Hospital.

Born September 28, 1879, in Nanticoke, Pa., Dr. Bennett was graduated from the University of Pennsylvania in 1901 and served his internship at City Hospital, Wilkes-Barre, Pa. He had a private practice in Scranton, Pa., for a brief period, and before going to Verona was connected with the Pennsylvania State Sanatorium at Hamburg. Dr. Bennet was active in pulmonary work since his graduation from medical school and was one of the pioneers in establishing state clinics in Pennsylvania, working with the widely known Dr. Harry Stites.

Dr. Bennett was a member of the Sanatorium Association, College of Chest Physicians, Essex County Medical Society, The Medical Society of New Jersey and the American Medical Association.

## DR. HENRY J. COLLINS

Dr. Henry J. Collins, who had practiced medicine in Trenton 27 years, died on June 21, 1945, in his 56th year.

A graduate of Georgetown University School of Medicine, Dr. Collins served with the Navy in World War I. He was a consultant at the Donnelly Memorial Hospital and assistant chief x-ray specialist at St. Francis Hospital.

Dr. Collins was a member of the Mercer County Medical Society, The Medical Society of New Jersey and the American Medical Association.

## CAPTAIN AMOS A. PLANTE

Captain Amos A. Plante, former Maplewood physician, was killed in France on May 23, 1945, in an airplane accident. Capt. Plante had been overseas since March, 1944, stationed in England.

Born in Mooers Forks, N. Y., in 1900, he was graduated from Columbia University College of Physicians and Surgeons in 1927 and interned at Orange Memorial Hospital. Capt. Plante had practiced in Maplewood since 1928.

When he entered the Army he was a medical examiner for Maplewood Draft Board 16, and was Board of Health physician since 1935. As part of his health work he was in charge of the township's Infant Welfare Clinic. In 1935 he was township police surgeon and helped to establish a first aid room in police headquarters.

Capt. Plante was a member of the Essex County Medical Society, The Medical Society of New Jersey and the American Medical Association.

## DR. MILLARD F. SEWALL

Dr. Millard F. Sewall, physician and surgeon in Bridgeton for thirty-nine years, died on June 4, 1945, after being in failing health for two years.

Dr. Sewall was born in Yorke, Maine, in 1878. He received an A.B. degree at Dartmouth in 1899 and his M.D. at Jefferson Medical College in 1903, and served at St. Agnes and Girard Hospitals in Philadelphia and Bridgeton Hospital. Dr. Sewall was a major in World War I and served in the St. Mihiel and Argonne offensives.

Dr. Sewall was a Fellow of the American College of Surgeons, a member of the Cumberland County Medical Society, The Medical Society of New Jersey and the American Medical Association.

## DR. JOHN Y. SINTON

Dr. John Y. Sinton, a prominent resident of Upper Freehold Township, died in Imlaystown on May 31, 1945, after a three-month illness.

Dr. Sinton, who was born in 1863, received his medical degree from the Medico-Chirurgical College of Philadelphia in 1908. After practicing in Philadelphia for several years, he moved to Imlaystown. He was very active in civic and fraternal affairs.

For many years Dr. Sinton was the school physician and was secretary of the Upper Freehold Township Board of Health.

He was a member of the Mercer County Medical Society, The Medical Society of New Jersey and the American Medical Association.

## DR. W. HENLEY SMITH

Dr. W. Henley Smith of Trenton died suddenly on June 1, 1945, at his home at the age of 52.

Dr. Smith was graduated from Jefferson Medical College in 1917. He was on the medical staff of Mercer Hospital.

Dr. Smith was a member of the Mercer County Medical Society, The Medical Society of New Jersey and the American Medical Association.

# COUNTY SOCIETY REPORTS

## BURLINGTON COUNTY

T. B. Dickson, M.D., Reporter

Carrying on the usual custom, the May meeting of the *Burlington County Medical Society* was a social gathering with the wives of the members present. The Burlington County dentists and their wives were invited and many attended.

DR. HAMMELL P. SHIPPS, the retiring President, made his farewell address. Out of 71 members 23 are in the Armed Forces. One of our members, Dr. Carlton Hogan, was killed in action in the Mediterranean Area. Dr. Shipps stated that the proposal of DR. J. HOWARD HORNBERGER for Second Vice-President of the State Society has been well received by other County Societies. In his address he also urged the support of the National Physicians Committee which is fighting socialized medicine and is trying to obtain coöperation between government and the medical profession. In closing, Dr. Shipps pointed out that to be a citizen in a republic like the United States entails certain responsibilities and obligations which citizens, especially physicians, must assume if they are to enjoy the rights and privileges of a democracy.

The incoming President, DR. THOMAS J. SUMMEY, made a short speech and took over the president's chair.

MR. HAROLD KENNEDY, famous New York actor and playwright, was the guest speaker of the evening. He told of some of his amusing experiences both on stage and back-stage. Mr. Kennedy gave a most interesting talk and held the attention of his audience throughout.

It is with sorrow that we announce the death of CAPTAIN JOHN R. SIDDALL of the Army Medical Corps. He died in an airplane crash on Ascension Island May 10, 1945, while on his way home on furlough.

## CUMBERLAND COUNTY

Norman W. Henry, M.D., Reporter

The regular meeting of the *Cumberland County Medical Society* was held at the Circle Restaurant in Vineland June 12, 1945, at 2:30 p.m. Twenty members were in attendance.

The meeting was called to order by the President, DR. GEORGE N. THOMAS of Vineland.

Dr. Albert B. Kump reported on the Wagner-Murray-Dingell Bill now up before Congress, lectures given by Dr. Edward F. Stegen of Chicago on the subject "Your Health—Take Care of It the Amercian Way", and a resolution which was passed at the State Society Welfare Committee meeting relative to Negro doctors.

An announcement was made concerning the death of DR. MILLARD F. SEWALL, who died June 4, 1945, at the age of sixty-seven. Dr. Sewell practiced as physician and surgeon in Bridgeton since 1906, and was an honorary member of this Society.

DR. PAUL N. JEPSON, orthopedic surgeon, discussed the treatments of "Spastic Birth Palsy". He briefly related the causes of such a condition under the heading of birth trauma and neuropathic undevelopment. The pathology is essentially that of laceration of the dura mater and hemorrhage involving the pyramidal tract. The symptomatology is that of late walking and a scissor gait. Some mental retardation usually accompanies this condition.

In treating "Infantile Cerebral Palsies" rehabilitation and muscle training are essential. Chemotherapy and physiotherapy are the best methods for securing good results.

The salt of prostigmine is excellent for securing muscle relaxation and abolishment of the deep reflexes. Prostigmine Bromide orally is best given in five mgm. doses four to eight times a day for a period of months. This secures the muscle relaxation for the training and reëducation of the spastic palsy.

A dinner was served after adjournment.

## HUDSON COUNTY

Harry J. Perlberg, M.D., Reporter

The final meeting of the *Hudson County Medical Society* for the official year of 1944-45 was held on May 1, 1945, at the Masonic Club in Jersey City. The meeting was called to order by the President, DR. WALTER D. WEBER, at 9:30 p.m.

The recommendation of the Executive Committee that the following resolution, suitably engrossed, be presented to DR. HENRY SPENCE as a token of friendship and appreciation, was unanimously approved:

> *Whereas,* Dr. Henry Spence has been a loyal and true member of Hudson County Medical Society for the past fifty-two years, its honored president during the official year of 1898-1899, its efficient treasurer from the year 1936 to the year 1942, and a member of its present Board of Trustees and Executive Committee, the Society now pauses to pay tribute to him as a physician in the most exalted sense of the word; to take cognizance of his steadfast devotion to the ideals of his chosen profession, and to make known to him the Society's gratitude; therefore, be it
>
> *Resolved,* That the Hudson County Medical Society accord official recognition to Dr. Spence for his many years of faithful membership; express to him the grateful appreciation of each and every member of the Society for his many and varied contributions to the welfare of the Society, not the least of which was his wise and dependable counsel; commend him for his sterling character, the ineffaceable mark of a true gentleman; make record of his kindliness, his quiet but keen humor, and his cordial presence among us; wish him good health and happiness for a long time to come; and confer upon him Honorary Membership in the Hudson County Medical Society.

DR. J. F. LONDRIGAN, President of the State Society, addressed the meeting, saying he was pleased

to announce that despite the purchase of a permanent home during the past year, the State Society is now in a position to reduce its assessment for the coming year from $22.00 to $20.00 per member.

The following were elected to membership: Dr. John B. Fabriele and Dr. John R. Rossi, Bayonne.

Dr. Charles M. Harris, Jersey City, was passed by Board of Censors for reinstatement.

It was regularly moved and seconded that the Secretary cast one ballot for the election of the nominees whose names were listed in the Report of the Nominating Committee made at the March meeting; also for the members of the Nominating Committee to serve in 1946 who were nominated from the floor at this meeting, and for Dr. Hugh H. Tyndall, as an additional Delegate to the State Convention, to serve for a period of three years, to 1948.

Capt. A. M. Kleinman, M.C., Assistant Chief of Medical Service, Halloran General Hospital, spoke on "Hepatitis".

The tremendous increase in the use of transfusions of blood and plasma during the past few years, both in military and civilian hospitals, has brought about the realization that a definite hazard is involved in the use of these preparations; namely, the development of jaundice. It is now recognized that human whole blood, plasma, or serum may occasionally contain an agent capable of producing jaundice when administered parenterally. The problem is of concern to the civilian medical profession as well as to the military because, due to the long incubation period, jaundice may develop in soldiers who are home on furlough or discharged from service.

*Etiology.* The causal agent is believed to be a heat stable and filtrable virus which resists freezing and drying for long periods of time. It can increase in a medium known to be suitable for the growth of a virus and it resists comparatively strong concentrations of phenol and merthiolate, the latter having been used unsuccessfully as a preservative in plasma which proved to be icterogenic. The virus has been found in the blood, nasopharyngeal washings, feces and urine of patients, particularly in the early stages of the disease. The results of successful experimental transmission of the disease to man suggest that the intestinal-oral circuit forms at least a part of the natural route of spreading the disease. The conclusion to be derived from the various studies is that naturally acquired infective hepatitis and hepatitis occurring after the injection of homologous blood or blood products, are identical diseases. Postinoculation hepatitis is due to the use of serum, plasma, or whole blood from a donor with the virus of infective hepatitis in his blood. The virus is present in the blood because the donor was suffering from hepatitis in a subclinical form and thus was not aware of it, or was in the incubation stage of the disease. It is also possible that the virus appears occasionally in the blood of an immune person. The naturally acquired disease is spread by droplet infection or by ingestion, and there is some evidence that the disease may be acquired naturally by people in contact with cases of post-inoculation hepatitis.

*Pathology.* The pathology of the various types of the disease is the same. In the early stages, there is swelling of the epithelial cells of the liver and dilatation of the sinusoids. This is followed by progressive changes in the nuclei to complete karyolysis, together with disintegration and necrosis of liver cells, rupture of sinusoids and disruption of liver cords. The process begins at the center of the lobule and proceeds peripherally. The degeneration and necrosis is accompanied by an accumulation of inflammatory cells. In the periportal area, the vessels are dilated, there is an inflammatory infiltrate, but the bile ducts are unchanged. The reticulum, which is at first unchanged, later becomes thickened and then broken up. The endothelial cells of the efferent veins become swollen, there is subendothelial inflammatory exudate, with thrombus formation. This endophlebitis may result in venous obstruction and ascites. Evidence of epithelial cell regeneration is abundant except in the fulminating and far advanced cases. The glycogen content of the liver is not appreciably decreased and the fat, while increased, is not a marked feature. Fatal cases show a picture typical of "acute or subacute yellow or red atrophy". The spleen is enlarged, hyperemic, and the follicles may be enlarged. The kidneys show "bile nephrosis", and there is commonly a bronchopneumonia.

*Incubation Period.* With some variation, the average incubation period for the naturally acquired disease is about one month, and for the inoculation type, about three months.

*Symptoms and Signs.* These are generally quite characteristic. There is a prodromal period during which there is a gradual onset of malaise, anorexia (almost a universal feature), and various degrees of nausea and vomiting. The urine becomes dark in color and the stools light, often clay-colored. However, some bile can usually be demonstrated in the stools or in the duodenal drainage. Occasionally the onset is acute—with chilliness, with or without sore throat, and fever, the latter subsiding as the jaundice appears. Jaundice generally appears on about the fourth day after the onset of symptoms, but may be delayed one to three weeks. The liver is palpably enlarged in about 25 per cent of cases, and the spleen in about 5 per cent. In mild cases, the symptoms subside in a few days, but jaundice may persist for one or two weeks. In the more severe cases, symptoms persist longer and are more marked. Some cases showed remissions and relapses, the latter frequently being precipitated by increased physical activity by the patient. The degree of severity of the jaundice or of the symptoms is no guide as to the ultimate prognosis. Fatal cases are characterized by the sudden onset of mental symptoms which lead rapidly to delirium, coma and death, often with hyperpyrexia. Prior to the onset of the terminal mental symptoms, the course of these patients is not different from those who recover. Very often, the development of symptoms of restlessness, insomnia, irritability, antagonism and non-coöperativeness leads to

the diagnosis of psychoneurosis, particularly in the non-jaundiced cases.

Convalescence is often prolonged and may be characterized by lassitude, fatigue, irritability and various degrees of digestive disturbances.

*Prophylaxis:* At present, there is no known practical method of preventing post-transfusion hepatitis, except in those cases where the donor is known and he can be studied for evidence of latent or overt hepatitis. There is no known disinfectant of blood, plasma or serum. Experiments are in progress to determine the efficiency of gamma globulin in preventing or attenuating post-transfusion hepatitis.

*Treatment:* Complete bed rest for a sufficiently long period is the most important consideration in the treatment of this disease. The diet should be attractively prepared and served, should be high caloric, high in carbohydrate and protein, and low but not devoid of fat. If the patient cannot tolerate food by mouth, parenteral feeding should be instituted. Large doses of vitamin supplements are given, particularly A, various fractions of the B complex, and K. Choline in doses of 0.5 gm. three times a day is also given; its value in these cases is uncertain, although its value in cirrhosis of the liver seems to be established.

Before discussing the paper, Drs. Perkel, Earl Halligan, McNenney, Alter, Macchia and Gleeson complimented Capt. Kleinman upon its excellence. Dr. Weber conveyed to the speaker the appreciation of the Hudson County Medical Society.

This being the final meeting of Dr. Weber's term of office, he expressed gratitude to his fellow-officers, the members of the various committees, and all others who had given him their support. He then greeted his successor, Dr. Hugh H. Tyndall of Weehawken, who was escorted to the platform by Drs. Norton and Conty.

After complimenting the speaker of the evening, Dr. Tyndall thanked the members of the Society for the honor accorded him, and in making brief mention of some of the objectives of his administration, pledged his best efforts in the interests of the Hudson County Medical Society.

Meeting adjourned at 11:50 p. m.

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## MONMOUTH COUNTY

Elsworth F. Baker, M.D., Reporter

The regular meeting of the *Monmouth County Medical Society* was held at the State Hospital, Marlboro, at 9:00 p. m., May 23, 1945.

In the absence of the President, the President-Elect, DR. GRANVILLE L. JONES, presided.

The following business was transacted. DR. J. BERKELEY GORDON announced that the Alcoholics Anonymous were holding regular meetings at the State Hospital on Wednesday evenings contacting the alcoholic patients at this hospital and interesting them in association with the group. Alcoholics Anonymous will hold an open meeting at the Boro Hall, Red Bank, in June, to which all physicians and lawyers in the county are invited.

Dr. Jones announced that the plan of the Veterans Medical Service Committee in which all members of the Medical Society could be designated as physicians to the veterans was agreeable to the Veterans Facility at Lyons. Also, the establishment of a Screening Clinic composed of specialists which veterans may attend and the clinic will refer them to a suitable physician for further care. If these plans are to be successful, the full coöperation of all physicians of the Society is required. All members of the County Society will receive a letter of explanation in the near future.

It was unanimously agreed that the June meeting, as usual, will be an outing and a committee will be appointed for arrangements.

Dr. Jones, Clinical Director of the State Hospital at Marlboro, then introduced the speaker of the evening, DR. GEORGES LUSSIER, who is in charge of the Children's Unit at Marlboro. His topic for the evening was "Various Features of the Juvenile Service at Marlboro".

Dr. Lussier emphasized that the psychopathology in children was different from that in adults in that in the former we are dealing with a growing and changing medium as opposed to the more static situation in the adults. This requires a different methodology in teaching and therapy. Children need to be segregated from the adults, otherwise the situation is detrimental to both.

The Children's Unit was opened on July 9, 1940, and to date 116 children have been admitted. The Unit consists of one cottage for girls and one cottage for boys. Children are received from every county of the state under regular commitment. It is preferable if they are first seen in one of the Mental Hygiene Clinics to determine whether they are suitable candidates and can profit by hospitalization in the Unit. Coöperation of the parents is very necessary. On admission a complete physical examination is done and intensive investigation made into the mental and social aspects of the child and his environment. Psychological and aptitude tests are given. Remedial reading and speech training, where necessary and electroshock, when indicated. Emphasis, however, is placed on psychotherapy.

Classes in education are held and grades extending from primary grades to High School taught with individual attention. Arrangements are made with a High School in the territory where suitable children can continue their education even though it is necessary that they remain in the hospital. Educational movies and discussions are held regularly with evening classes for dancing, physical education and sex education. Mixing of boys and girls is encouraged so that a normal relationship can be established. Plays are produced by the children and the girls are given occupational therapy in the form of sewing, embroidering, crocheting and allowed to design and make their own clothing while the boys are given carpentry, gardening, etc. Domestic Science had to be discontinued because of the shortage of dieticians. Table manners are taugh and encouraged by means of an Honor Table. Children's birthdays are celebrated by parties. Nature studies are held with trips into

the surrounding country and the children are allowed pets. Musical instruction with weekly concerts is also given and weekly religious service held for all denominations. Holidays are celebrated by suitable decoration and entertainment. Disciplinary constructive measures are of a positive nature. Those who get along are allowed more privileges, even week-ends at home if felt advisable. So far there have been only two escapes, one attempt at suicide and one attempt at sex play.

Staff meetings are held weekly for a thorough study of the children and additional plans made for the reëducation of each child.

The Unit, at present, has 41 children.

Dr. Lussier emphasized the importance of having a satisfactory Staff who are emotionally stable and well integrated themselves, that a great deal of patience is necessary. The concern is not what the child does but why he does it and he is felt entitled to his behavior until causes can be found for it and corrected. Suitable outlets are allowed for aggressive behavior.

Mrs. Linde, Supervisor of the Children's Unit, led the discussion of Dr. Lussier's very interesting paper and stated that she merely wished to emphasize what Dr. Lussier had already said. She stated that the atmosphere in which the child lived is an essential feature of his reëducation; that the children are surrounded by an environment of justice, truth, order and serenity; and that a satisfactory Staff is of major importance in the human relationships of these children as most of their difficulties have been due to a lack of satisfactory relationships. They are taught that they must change their attitude toward their home environment since their home environment will not change. Children are encouraged to give constructive criticism to each other and only encouraging and constructive material are allowed. Infinite patience is required. Self discipline is strived for but excessive demands are not made. The environment accommodates itself to the child. Work must be simple and straight forward with an immediate follow through. Disturbed children react unfavorably on the group and should be segregated. Work with the children and education of the parents must be coördinated.

Mr. Robert Stone, Psychologist, followed with a brief discussion on remedial reading. He stated that 12 per cent of the children in New York City have a reading disability. Many failures in school are due to this handicap and it may lead to behavior problems. The mental hygiene of learning to read is even more important than the mere ability to read since no organism is at home in an environment where it cannot function. When the child can read he obtains a new interest in life and conflicts begin to dissolve. Life becomes more interesting and the child more stable.

A lively discussion followed with numerous questions about the Unit.

Dr. Lussier closed the discussion by stating that the Unit was more suitable for behavior problems and the pre-psychotic and psychoneurotic child, that too much could not be expected from the frank psychoses.

## PASSAIC COUNTY

J. Reuben Budd, M.D., Reporter

The regular meeting of the *Passaic County Medical Society* was held at the Board of Freeholders' Meeting Room, Administration Building, Paterson, on May 15, 1945. The meeting was called to order by the President, Dr. William M. Sullivan.

Dr. Sullivan introduced the speaker, Dr. Joseph Felsen, Diplomate American Board of Pathology and member of the American Public Health Association.

The subject was "The Infectious Diarrheas with Particular Reference to Infants". Dr. Felsen, with the aid of lantern slides, covered the highlights of the vast subject and placed a great deal of emphasis on bacillary dysentery. Interesting data on the Jersey City epidemic was presented. The importance of careful laboratory investigation was stressed.

Dr. Felsen pointed out the necessity for a proper routine and good teamwork in proctoscopic examinations. The recent advances in treatment were outlined. The fact that sulfaquinidine is readily absorbed through an ulcerated lesion was emphasized.

At the business meeting, election of officers for the new year and election of two new members took place. Officers elected are:

Dr. Howard H. Nye, President
Dr. Harry Wolfson, First Vice-President
Dr. Leon E. De Yoe, Second Vice-President
Dr. Irving Okin, Secretary
Dr. Theodore K. Graham, Treasurer
Dr. J. Reuben Budd, Editor and Reporter

Board of Censors: Dr. Francis W. Ash, Chairman; Dr. Charles J. Murn and Dr. William M. Sullivan

Membership: Dr. Leslie London, Dr. Alfred Bronner.

## SUMMIT MEDICAL SOCIETY

Carroll S. Thompson, M.D., Secretary

The *Summit Medical Society* held its last meeting of the season on Tuesday, May 29, 1945, at 9:00 p. m. There were 20 members and 10 guests present.

Dr. F. I. Krauss presented a report of the Committee on Revision of the Quarantine Laws of the City of Summit.

The membership of the Society was increased by the addition of six new members.

The last meeting finds the Summit Medical Society in a very healthy and flourishing condition.

The following officers were elected:

President: Dr. John D. Tidaback
Vice-President: Dr. F. Cleveland Davis
Secretary: Dr. Evelyn Holt
Treasurer: Dr. Carroll S. Thomson

Dr. Raymond D. Baker was made chairman of the Physicians Committee of the Disaster and Relief Committee of the American Red Cross of Summit.

The meeting was then turned over to the Mental Hygiene Society of Union County and a symposium was conducted concerning their work and future plans for their clinic in Summit.

# WOMAN'S AUXILIARY

## ACCEPTANCE SPEECH

Mrs. William E. Dodd, President

I do not know how to express adequately my appreciation of the honor you have conferred upon me in electing me President of the Woman's Auxiliary to The Medical Society of New Jersey.

The By-Laws define the duties of a president somewhat as follows: To preside at the meetings and to promote the objects of the Woman's Auxiliary. That seems simple enough, but in reality it is much more than that. The president is, temporarily at least, the head of the organization, and the organization is judged by her.

I am beginning to realize that our work does not begin and end in our Board meetings, that in my meeting with others I shall be known during my term of office as President of this Auxiliary. I shall derive honor, therefore it behooves me by my conduct to reflect honor on my Auxiliary.

It is my duty to assist in promoting good fellowship, to conserve the resources, to increase our membership, and to follow whatever suggestions the National Auxiliary may submit.

And so I ask myself the question, "Can I do these things acceptably to the members?" I can truthfully answer that I can try. I will assume my duties cheerfully, and discharge them to the best of my ability.

Many aims of the past administration will be continued. We will be constantly on the alert for any unfavorable legislation. Health education and greater interest in the Society for the Relief of Widows and Orphans, and the Medical-Surgical Plan, will be stressed.

But, my friends, I realize that, alone, a president can do nothing. Therefore, I trust that, as I shall endeavor to carry out your wishes in all matters, so may I have at all times your fullest confidence, your advice, your sympathy and support, to the end that our Auxiliary may grow in strength and numbers during my term of office.

Again let me thank you for the honor and assure you of my desire to justify the confidence you have reposed in me.

I pledge my loyalty and devotion to the Woman's Auxiliary to The Medical Society of New Jersey. I will support its activities, protect its reputation, and ever sustain its high ideals.

## REGIONAL CONFERENCE

Mrs. Lodovico Mancusi-Ungaro, Chairman of Publicity

The Woman's Auxiliary to The Medical Society of New Jersey held a Regional Conference in the Executive Offices of the Society, Trenton, on Tuesday, June 19, 1945. Mrs. William E. Dodd of Beach Haven, President, presided.

This, the Second Annual Regional Conference, was called by the President to inform the Committee Chairmen and County Auxiliary Presidents of their duties and the anticipated program for the coming year.

Dr. William E. Dodd of Beach Haven, Chairman of the Advisory Committee to the Woman's Auxiliary, addressed the conference and stressed the importance of the public relations work in presenting the viewpoint of The Medical Society of New Jersey.

# AUXILIARY REPORTS

## Atlantic County

Mrs. Samuel Salasin, Chairman of Publicity

The annual election and installation of officers of the *Woman's Auxiliary to the Atlantic County Medical Society* took place at the Madison Hotel, May 11. Mrs. Robert A. Bradley was elected President; Mrs. Charles Hyman, President-Elect; Mrs. Edward Dyer, First Vice-President; Mrs. William Roop, Second Vice-President; Mrs. Samuel Goldstein, Recording Secretary, and Mrs. Harry Subin, Corresponding Secretary.

Mrs. Daniel Reyner, the retiring President, was elected chairman of the County Store Booth at the Flower Mart for the Visiting Nurses Association. To raise the funds to run this booth Mrs. Anthony Merendino entertained the members of the Auxiliary at a cocktail party Saturday, May 12, 1945.

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## Essex County

Mrs. Rocco S. Marra, Chairman of Publicity

The Annual Spring Luncheon and meeting of the *Woman's Auxiliary to the Essex County Medical Society,* including the election and installation of officers, was held Monday, May 28, 1945, at the Academy of Medicine at 12:00 p.m. Mrs. S. Bernard Kaplan of East Orange was named President. Other officers are: President-Elect, Mrs. Frank S. Forte; Vice-President, Mrs. Daniel E. Kavanaugh; Treasurer, Mrs. William A. Donahue; Recording Secretary, Mrs. Otto G. Matheke Jr.; Directors for three years, Mrs. Harrold A. Murray and Mrs. Irving V. Berney; Mrs. Philip Santora was elected a Director to fill an unexpired term; Corresponding Secretary, Mrs. William D. Crecca.

The retiring President, Mrs. Lodovico Mancusi-Ungaro, reported on activities during the last year. She was presented a Past President's pin by Mrs. Asher Yaguda.

Guest speaker at this meeting was Miss Dorothy E. Matheke, who has just returned from India where she served for ten months as Administrative Secretary to the Regional Supervisor of Red Cross Installations in Assam and Burma. She spoke on "The Red Cross in India". Miss Matheke described her trip to India, relating her experiences on the trains, having traveled during the very rainy season. She told of the many ways the Red Cross entertained the soldiers in India. Our boys enjoyed mostly the repeated parties held, in which home-made cookies and ice cream were served followed by dancing with Red Cross workers.

A citation was presented by Mr. Harry F. Manning, Deputy Administrator of the War Finance Committee, to the Woman's Auxiliary for selling $36,000 worth of war bonds, which bought a Troop Carrier for the U. S. Navy.

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## Gloucester County

Mrs. C. A. Bowersox, Press and Publicity Chairman

The *Gloucester County Auxiliary* held a covered dish luncheon and business meeting at the home of Mrs. Paul M. Pegau, Briar Hill Lane, Woodbury, on Thursday, May 17, 1945, at 1:00 p.m. Nine members were present. Mrs. H. B. Diverty, President, presided.

Resignations of Mrs. Diverty and Mrs. Harris were regularly moved and accepted. Mrs. Bowersox, Chairman of the Nominating Committee, reported on the nominations for the two offices to be filled. These were moved and passed. Mrs. Fred Faux of Woodbury, former Vice-President, is succeeding Mrs. Diverty, as President; Mrs. P. M. Pegau, Vice-President; Mrs. C. I. Ulmer, President-Elect; Mrs. William Pedrick, Secretary; Mrs. G. R. Booth, Treasurer.

It was announced by Mrs. Faux that an executive meeting will be held on June 8, 1945, at 2:00 p.m. at her home.

The Auxiliary members wish to thank Mrs. Diverty for her sincere efforts in making the organization so successful the past year.

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## Passaic County

Mrs. Irving Silverman, Chairman of Publicity

The *Woman's Auxiliary to the Passaic County Medical Society* concluded its activities of the current year with a luncheon on May 21, 1945, at the Howard Johnson restaurant, Clifton. The President, Mrs. Joseph E. Mott, presided at the annual meeting which immediately followed.

The guest of honor, Mrs. Ruth Lee, Secretary to the Passaic County Medical Society, was introduced to the members by the President and most sincerely thanked for all her kind and generous coöperation during the year.

Mrs. Irving Hayman was appointed as the new Arts, Hobbies and Medical History Chairman by Mrs. Mott to succeed Mrs. Charles B. Russell who recently resigned because of ill health.

Reports were made on the tremendous part the Auxiliary played in the recent Cancer Campaign, with Mrs. Joseph R. Jehl reporting for Clifton, Mrs. P. J. DeBell for Passaic and Mrs. R. J. McDonald reporting on the entire county. An additional contribution was decided upon by the members as an organization gift. Also substantial amounts were donated to the Red Cross Chapters of Paterson, Passaic and Clifton.

## BOOKS RECEIVED FOR REVIEW

PSYCHOLOGY OF WOMEN: A Psychoanalytic Interpretation. By Helene Deutsch, M.D. v. 2, *Motherhood.* Pp. 498. New York, Grune & Stratton. 1945. $4.50.

AGEING AND DEGENERATIVE DISEASES. Ed. by Robert A. Moore. Biological Symposia, vol. XI. Pp. 242, illustrated. Lancaster, Pa., Jaques Cattell Press. 1945. $3.00.

TECHNICAL METHODS FOR THE TECHNICIAN. By Anson Lee Brown, A.B., M.D. Director of Dr. Brown's Clinical Laboratory and School for Technicians, Columbus, Ohio. Pp. 706. Pub. by the author. 1944. $10.00.

RYPINS' MEDICAL LICENSURE EXAMINATIONS; Topical Summaries, Questions and Answers. 5th ed., revised and edited by Walter L. Bierring, M.D., F.A.C.P., M.R.C.P., Edin. (Hon.), with the collaboration of a review panel. Pp. 546. Philadelphia, J. B. Lippincott Co. 1945. $6.00.

HAY FEVER PLANTS; Their Appearance, Distribution, Time of Flowering, and Their Rôle in Hay Fever, with special reference to North America. By Roger P. Wodehouse, Ph.D. Pp. 245, illustrated. Waltham, Mass., The Chronica Botanica Co.; New York, G. E. Stechert & Co. 1945. $4.75.

TEXTBOOK OF NEUROPATHOLOGY. By Arthur Weil, M.D. 2d ed. Pp. 356. New York, Grune & Stratton. 1945. $5.50.

## BOOK REVIEWS

**Laboratory Methods of the United States Army.** Edited by James Stevens Simmons and Cleon Joseph Gentzkow. 5th ed. Philadelphia, Lea & Febiger. 1944. $7.50.

This edition was prepared to meet a war-time need for a practical handbook for use of the medical and sanitary laboratories of the Army. It does not presume to give the significance of tests, but it does constitute a valuable reference for officers and technicians who assume responsibility for expanding laboratory services. Emphasis is placed on proper care of equipment and the value of cleanliness and painstaking technics. Considerable space is given to tests for parasites and to routines followed in studies of some of the tropical diseases. In many cases only one or two tests are given, obviously those considered most applicable to army procedures. The volume has been approved by the Surgeon General of the Army.

CAROLYN VALENTINE, B.S.

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**Lippincott's Quick Reference Book for Medicine and Surgery;** A Clinical Diagnostic and Therapeutic Digest of General Medicine, Surgery, and the Specialties, compiled systematically from modern literature by George B. Rehberger, A.B., M.D. 12th ed. Pp. 1460, illustrated. Philadelphia, J. B. Lippincott Company. 1944. $15.00.

The title of the book is a good description of what it contains. It is divided into eleven parts. Part I, which takes up almost half of the volume, deals briefly with the common and some of the less common subjects of medicine and surgery, giving a brief synopsis of the various diseases encountered in an average practice. Parts II to X treat the specialties in a similar manner. Part XI concerns itself with drugs, their pharmacology and usage, dosage at different ages, modes of action and toxic effects. In addition, the administration of anesthetics and an excellent index of subject headings, and the equivalents of metric and apothecary weights and measures are given. The pharmacological index in this last part will be a fine aid in selecting a drug for treatment of both organic and functional disorders.

Each disease is listed alphabetically; its diagnostic features briefly discussed, followed by its course, prognosis and finally treatment. The treatment is concise and complete, including dosage of the drugs and the technique of its use. Diagnostic laboratory tests are supplied where necessary and in addition quarantine and prophylactic measures are considered where indicated.

The book is what the author meant it to be, a quick reference for the busy practitioner. The general practitioner has not the time to go through the vast amount of medical literature to acquaint himself with the best and latest information on the various disorders of the body. This book enables him to acquire information quickly and easily. It is also helpful for the country physician who has not the means to consult many authors on a subject with which he must acquaint himself immediately.

ERNEST C. HILLMAN, JR., M.D.

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**Art of Resuscitation.** By Paluel J. Flagg, M.D. Pp. 453, illustrated. New York, Reinhold Publishing Company. 1944. $5.00.

A very complete compilation of the present-day knowledge of asphyxia and resuscitation is given in this book. Dr. Flagg begins with definitions of the terms used in this field and gives an interesting summary of the historical background. He spends a great deal of space on asphyxia, in fact much more than upon the art of resuscitation. He describes asphyxia arising from many different causes, such as high altitudes, submersion, anesthesia, clinical diseases and so forth.

The author speaks of the inadequate training of the medical profession in the treatment of asphyxia and how the treatment is often relegated to lay groups such as the Rescue Squad and Fire Department. He mentions automatic machines and their effect upon the treatment of the patient.

This book contains much information that could only otherwise be found by reading many widespread articles. His comments upon the relation of the anesthetist, pneumatologist, and other specialists in medicine are quite pertinent.

George F. Browne, M.D.

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**Pathology of Internal Diseases.** By William Boyd, M.D., LL.D., M.R.C.P., Ed., F.R.C.P. London. Dipl. Psych. F.R.S.C. 4th ed. Pp. 857 with 366 engravings and 8 color plates. Philadelphia, Lea & Febiger. 1944. $10.00.

Like its predecessors, this book constitutes one of the true classics of modern medical literature. The chief asset of the present edition over its forerunners lies in a thorough revision of the chapters on cardio-vascular diseases and inclusion of many more recently described diseases or disorders such as blast injury, Meig's syndrome, alloxan diabetes, crush nephritis, sulphonamide nephritis, Waterhouse-Friderichsen's syndrome and the Rh factor in erythroblastosis fetalis.

Written in the author's own inimitable style, it should be a "must" on the reading list of every internist. The chapters are well organized and the typography and numerous illustrations further contribute to the magnetic hold of this review of pathology.

Arthur J. D'Alessandro, M.D.

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**Fundamentals of Internal Medicine.** By Wallace Mason Yater, A.B., M.D., M.S. (in Med.), F.A.C.P. 2d ed. Pp. 1204. New York, D. Appleton-Century Co. 1944. $10.00.

A one-volume system of medicine which is well thought out and planned. The style is readable and the trend of thought is well maintained. The book is not so comprehensive in subject matter or in detailed information on several subjects as are some other single volumes of medicine, but it is a useful addition to any library. It is well indexed and the material is easily found.

The section on diseases of the kidney could be more up-to-date. Many of the former students of Dr. Yater will recognize in some of his chapters his clinical lectures.

It is an excellent book for the student of internal medicine and is a good addition to the library of the general practitioner for a quick reference and quick over-all summation of most subjects.

F. Parker Willey, M.D.

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**Internal Medicine:** Its Theory and Practice, in contributions by American authors. Ed. by John H. Musser, B.S., M.D., F.A.C.P. 4th ed. Pp. 1518, illustrated. Philadelphia, Lea & Febiger. 1945. $10.00.

This textbook covers the essential facts of medical diseases, and as such is recommended to the physician. The contributors are prominent men in medicine. The material is so arranged as to be easily accessible.

In this edition medicine is brought up-to-date. The contributors deal with the sulfonamides, thiouracil and penicillin in the section on the newer therapies. War medicine is an added feature. It is discussed in the sections of psychiatry and neurology and the sections on protozoan and metazoan diseases. Much has been added to the chapters on virus and rickettsial diseases because of our increased knowledge in these departments.

The same high standard obtains in this edition as in all of the previous ones.

Marvin Oransky, M.D.

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**Penicillin Therapy,** Including Tyrothricin and Other Anti-Biotic Therapy. By John A. Kolmer, M.D. Pp. 302. New York, D. Appleton-Century Co. 1945.

This book provides a review of the chemotherapeutic compounds of biologic origin, including the history of their development and consideration of their properties, potentialities and limitations. The greater part of the book, of course, is devoted to penicillin, which is completely covered from methods of production and assay through pharmacology and toxicology to therapeutic indications and methods of administration. Results of penicillin therapy in various types of infections are reviewed and compared with other types of treatment. Indications for various types of supplementary treatment are given.

Tyrothricin, gramicidin, streptomycin, streptothricin and chlorophyll are also reviewed briefly. Reference is also made to patulin, clavacin and certain other antibiotics which have not proven to be very useful as therapeutic agents.

Experimentation with antibiotics is progressing so rapidly that the author found it necessary to add an appendix, setting forth certain developments which had occurred during the writing of the book.

General practitioners as well as specialists should find this book a useful addition to their libraries. Dentists will be interested particularly in the chapter on penicillin and tyrothricin therapy in relation to dentistry and oral surgery.

Glenn S. Usher, M.D.

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**Doctors at War.** Edited by Morris Fishbein, M.D. Pp. 418, illus. New York, E. P. Dutton & Co., Inc. 1945. $5.00.

The magnificent and inspirational story of American doctors in action in World War II, France, Africa, New Guinea and all the theaters of war are recorded together with the vital discoveries made in the heat of battle and contributing to the welfare of mankind. This book is written for the layman and the physician. Sixteen leading authorities give stirring accounts of the branch in which he has seen action. The volume is profusely illustrated with scenes from actual frontline medical stations and the whole reads like a thrilling novel.

Read it by all means, for a better understanding of the contributions of doctors to the care of the wounded, and therefore to the future care of all citizens.

Carolyn Valentine, B.S.

# THE TRANSACTIONS OF THE OFFICIAL 179th ANNUAL MEETING OF THE MEDICAL SOCIETY OF NEW JERSEY

**The Claridge Hotel, Atlantic City, New Jersey, May 23, 1945**

## TRANSACTIONS

### 1945 Annual Meeting

#### Foreword

The 1945 Convention of The Medical Society of New Jersey was cancelled upon receipt of a communication from the War Committee on Conventions, Washington, D. C., dated February 23, 1945, in which it was stated that our application to hold our regular three-day session at the Claridge Hotel, Atlantic City, May 22-24, 1945, had been reviewed and it was the consensus of the Committee that the meeting be deferred until a later date, therefore permission was denied.

On April 15, 1945, the Board of Trustees took action to have the Board act in lieu of the House of Delegates by meeting at the Claridge Hotel in Atlantic City on the evening of May 22nd and during the day of May 23rd; the Nominating Committee to meet on the evening of May 22nd and report to the Board on May 23rd.

Legal opinion on this action of the Board was received from our Counsel, Mr. Wall, who stated he had no doubt of the Trustees' power to act and that when one considered the reason behind the restriction imposed by the War Committee on Conventions, it was plain that the Board had every power except to hold a meeting in excess of the numbers that the restriction permitted.

A second application was sent to the War Committee on Conventions requesting permit to hold a business meeting of the House of Delegates on May 23, 1945, at the Claridge Hotel in Atlantic City. A reply from the Committee, dated April 24, 1945, stated it was their consensus that the business meeting should be deferred, therefore permit was denied.

Subsequently a resolution was received from the Monmouth County Medical Society which questioned the constitutionality of the Trustees' action. A similar resolution was also received from the Union County Medical Society.

It was deemed advisable to seek further legal opinion. This was obtained from Mr. John F. Bruther, Attorney, who concurred in Mr. Wall's opinion and stated further that the proposal of Monmouth County that the membership of the House of Delegates be numerically reduced to come within the purview of the order promulgated by the War Convention Committee (50) was in absolute contravention of our Constitution and was devoid of any legal authority to support it. In conclusion, Mr. Bruther stated that the Supreme Court has frequently enunciated the simple but sound proposition that you cannot make rules in the middle of the game, and that the pronouncement was completely dispositive of the resolution presented by the Monmouth County Medical Society. He therefore recommended that we accept Mr. Wall's advice and proceed in accordance with his directions.

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In lieu of the House of Delegates the Board of Trustees met at 10:25 a. m., Wednesday, May 23, 1945, at the Claridge Hotel, Atlantic City.

Those present were: Dr. Norton, Chairman, who presided; Drs. North, Young, Fithian, Hawkes, Hornberger, Coleman, McBride, Costello, Alexander, Green, Schaaf, Stahl, Londrigan and Lee. Dr. Crowe was excused. Also present were Drs. Barkhorn, Herrman, Nichols, Sica, Johnsen, Hollinshed and Scott.

#### Approval of 1944 Transactions

The 1944 Transactions of the House of Delegates were approved upon motion by Dr. Hornberger, second by Dr. Lee, and unanimously carried.

#### Annual Reports

Dr. Londrigan moved that the Annual Reports as printed in the May, 1945, *Journal* be approved and that the specific recommendations contained in the reports of the Publication Committee, Legislative Committee, the Advisory Committees on Medical Care of the Indigent and Low Wage Group, Cancer Control, and Tropical Diseases, be concurred in. Second by Dr. Coleman and unanimously carried.

### PUBLIC RELATIONS

Drs. Sica, Johnsen and Nichols addressed the Board and urged that an intensive public relations program be carried out by the State Society to inform the public of the viewpoint of organized medicine and that a publicity agent be employed for this purpose.

Upon action by the Board, the Chairman appointed Drs. Alexander, Scammell and Londrigan as a Committee from the Board to work with the Subcommittee on Public Relations in setting up a public relations policy for the State Society.

### BUDGET FOR 1945-1946

Dr. North, Chairman of the Finance and Budget Committee, presented the following budget for the fiscal year, June 1, 1945, to May 31, 1946, and moved its adoption. Second by Dr. Costello and carried.

BUDGET FOR 1945-1946

| | |
|---|---|
| A- 1—Acting Executive Officer's Salary | $ 1,000.00 |
| A- 2—Executive Salaries | 6,110.00 |
| A- 3—Executive Office Expenses | 1,200.00 |
| A- 4—Executive Travel | 800.00 |
| A- 5—Permanent Home | 5,000.00 |
| A- 6—Treasurer | 150.00 |
| A- 7—Finance and Budget Committee | 50.00 |
| A- 8—Bonding | 82.00 |
| A- 9—Audit | 330.00 |
| A-10—Secretary, Official List, Transactions | 2,000.00 |
| A-11—Unemployment Compensation Tax | 175.00 |
| Social Security Tax | 190.00 |
| A-12—Insurance | 225.00 |
| B- 1—Journal Publication | 15,000.00 |
| B- 2—Cuts | 150.00 |
| B- 3—Journal Salaries | 2,340.00 |
| B- 5—Journal Office Expenses | 500.00 |
| B- 6—Journal Travel | 200.00 |
| C- 2—Welfare Committee | 1,000.00 |
| C- 3—Legislative Committee | 4,500.00 |
| C- 4—Public Health Committee | 1,000.00 |
| C- 5—Public Relations Committee | 6,000.00 |
| C- 6—Medical Practice Committee | 1,200.00 |
| D- 1—President | 2,500.00 |
| D- 2—A. M. A. Delegates, Chicago, 1945 | 750.00 |
| D- 3—Conference Dues | 50.00 |
| D- 8—Woman's Auxiliary | 1,000.00 |
| D-11—Medical Service Administration | 10,382.00 |
| D-13—Post-Graduate Education | 100.00 |
| E —Contingent and Bonus | 6,000.00 |
| F —Legal | 1,000.00 |
| G —Annual Meeting | 1,000.00 |
| H —Pension, J. B. Morrison, M.D. | 1,500.00 |
| | $73,484.00 |

### DUES FOR 1946

Upon motion by Dr. North, second by Dr. Costello and unanimously carried, the annual per capita assessment of $20.00 upon the members of each component society was approved.

### REMISSION AND CREDIT OF DUES

Dr. Londrigan moved that the State Society continue its policy of giving dues credit or remission for members in the Armed Services. Second by Dr. North and unanimously carried.

It was also moved by Dr. Londrigan, second by Dr. Costello and unanimously carried, that the State Society give a dues credit or remission to members serving with other war agencies.

A third motion by Dr. Londrigan, second by Dr. Young and unanimously carried, was that members of the State Society be given a dues credit or remission for the first full year's dues after discharge from Service.

### REPORT OF THE TREASURER

Dr. Young presented the following Treasurer's report which of necessity could not be complete since the fiscal year does not close until May 31st. Dr. Londrigan moved its adoption, second by Dr. North, and unanimously carried.

TREASURER'S REPORT
1944-1945

| | | |
|---|---|---|
| Balance, June 1, 1944 | | $ 93,086.21 |
| RECEIPTS—June 1, 1944-May 14, 1945: | | |
| Assessments: | | |
| Atlantic County | $ 1,672.00 | |
| Bergen County | 4,928.00 | |
| Burlington County | 1,100.00 | |
| Camden County | 2,816.00 | |
| Cape May County | 440.00 | |
| Cumberland County | 1,056.00 | |
| Essex County | 18,771.50 | |
| Gloucester County | 726.00 | |
| Hudson County | 7,876.00 | |
| Hunterdon County | 594.00 | |
| Mercer County | 3,740.00 | |
| Middlesex County | 2,684.00 | |
| Monmouth County | 2,200.00 | |
| Morris County | 1,925.00 | |
| Ocean County | 396.00 | |
| Passaic County | 5,874.00 | |
| Salem County | 462.00 | |
| Somerset County | 924.00 | |
| Sussex County | 440.00 | |
| Union County | 5,654.00 | |
| Warren County | 506.00 | |
| | | 64,784.50 |
| Interest | | 178.68 |
| Sale of Maternal Welfare Books | | 123.20 |
| Revenue Unexpected | | 30.75 |
| Journal Advertisements—net | | 17,129.00 |
| Apartment rental and sale of house fixtures | | 355.00 |
| Net Receipts | | $175,687.34 |

DISBURSEMENTS—June 1, 1944-April 30, 1945

*Budget Accounts*

| | |
|---|---|
| A- 1—Executive Officer Salary | $ 916.66 |
| A- 2—Executive Salaries | 4,264.56 |
| A- 3—Executive Office Expenses | 683.03 |
| A- 4—Executive Travel | 466.44 |
| A- 5—Rental—222 W. State Street | 2,310.00 |
| A- 6—Treasurer | 28.20 |
| A- 7—Finance and Budget Committee | 11.52 |

| | |
|---|---|
| A- 8—Bonding | 82.00 |
| A- 9—Audit | 327.46 |
| A-10—Secretary | 1,521.27 |
| A-11—Unemployment Compensation Tax | 101.74 |
| Social Security Tax | 228.55 |
| A-12—Insurance | 198.78 |
| B- 1—Journal Publication | 12,668.40 |
| B- 2—Journal Cuts | 15.18 |
| B- 4—Journal Salaries | 1,920.00 |
| B- 5—Journal Office Expenses | 338.51 |
| B- 6—Journal Travel | 45.19 |
| C- 2—Welfare Committee | 332.35 |
| C- 3—Legislative Committee | 4,370.68 |
| C- 4—Public Health Committee | 329.17 |
| C- 5—Public Relations Committee | 114.65 |
| C- 6—Medical Practice Committee | 44.01 |
| D- 1—President | 1,215.54 |
| D- 2—A. M. A. Delegates—June, 1944 | 733.70 |
| D- 3—Conference Dues | 25.00 |
| D- 8—Woman's Auxiliary | 726.74 |
| D-11—Medical Service Administration | 10,048.66 |
| D-14—Social Security Committee | 1,712.45 |
| E —Contingent | 1,714.49 |
| G —Annual Meeting | 515.53 |
| H —Pension | 1,375.00 |
| | $ 49,385.46 |
| Taxes withheld on salaries | 25.54 |
| | $ 49,359.92 |
| Accounts Payable, May 31, 1944 | 220.68 |
| Permanent Home | 44,503.51 |
| Scientific Research Fund—Transfer to separate account | 10.00 |
| Remission of 1944 dues: | |
| Essex County $286.00 | |
| Gloucester County 22.00 | |
| Hudson County 66.00 | |
| Middlesex County 22.00 | |
| Morris County 44.00 | |
| Passaic County 66.00 | |
| Union County 93.50 | |
| | 599.50 |
| Net Expenses | $ 94.693.61 |
| Balance, May 14, 1945 | 80,993.73 |
| | $175,687.34 |

## Honorary Member

Dr. McBride, Chairman of the Honorary Membership Committee, presented the recommendation of his Committee for the election of Dr. Lucius F. Donohoe, Bayonne, as an Honorary Member of the State Society.

Dr. Costello moved the election of Dr. Donohoe, second by Dr. Londrigan and unanimously carried.

## Amendments to the Constitution and By-Laws

The amendment to the Constitution, Article VI, read at the 1944 Annual Meeting and published in accordance with Article XII, was unanimously adopted upon motion by Dr. Alexander, second by Dr. Costello.

"The Board of Trustees shall be the executive body, and shall be composed of the *'Junior Past President,'* * * *"

The amendment to the By-Laws, Chapter IX, Section 2a, to make this section conform to By-Law amendments passed in 1944, was unanimously adopted upon motion by Dr. Alexander, second by Dr. Costello.

"On the first day of January in each year there shall be levied on each component society a per capita assessment on the membership of such component society, as hereinafter set forth, to be paid to the Treasurer of the Medical Society of New Jersey not less than five days before the *'first'* of March, * * *"

## Procurement and Assignment

A report from Dr. Charles H. Schlichter, Chairman, Procurement and Assignment for New Jersey, was read.

The report stated that although no definite information is available, it is felt that Procurement and Assignment may be discontinued during the coming year. The Army discontinued the enrollment of physicians in the fall of 1944 because of the increased relative need of physicians for the Navy. At this time there are not an appreciable number of additional physicians available without jeopardizing the safety of our communities and hospitals. Very few physicians remain in civilian life who are considered available but who have not applied for a commission.

The most serious and difficult problems during the year were: (1) the procurement of proper intern and resident staffs for hospitals; (2) obtaining release from military service of physicians to fill critical needs which have developed in some hospitals and communities because of civilian physician casualties; (3) procurement of physicians to act as industrial physicians in our war plants; (4) the determination of the number of physicians practicing in New Jersey, their distribution, their types of practice, and their physical potentials.

Another problem was the attitude of Procurement and Assignment toward Essex College of Medicine and Surgery. Prior to approval of the College by the State Board of Medical Examiners, Procurement and Assignment refused to request deferment from local boards for its students. Now that the school has been given approval to conduct its first year of instructions, we shall attempt to have its students deferred and will take proper steps to secure the return of the men now in service to make up their teaching staff.

Dr. Londrigan moved that the report be accepted after deletion of that section dealing with the Essex College of Medicine and Surgery, inasmuch as the Society has not yet approved the College. Second by Dr. Costello and unanmously carried.

Upon motion by Dr. McBride, second by Dr. Londrigan and unanimously carried, the Secretary was instructed to write on behalf of the State Society to Dr. Schlichter and thank him and his associates in Procurement and As-

signment for the excellent work done in New Jersey.

### Election

The report of the Nominating Committee was received, each nominee was voted upon individually; and the Secretary was instructed to cast a ballot declaring the following nominees elected:

President-Elect: Frank G. Scammell, Trenton (1946)
First Vice-President: Royal A. Schaaf, Newark (1946)
Second Vice-President: J. Howard Hornberger, Roebling (1946)
Secretary: Alfred Stahl, Newark (1946)
Treasurer: George J. Young (1946)
Trustees—
Second District: James F. Norton, Jersey City (1948)
Third District: Harry R. North, Trenton (1948)
Fourth District: Thomas B. Lee, Camden (1948)
Fifth District: David W. Green, Salem (1948)
Councilors—
First District: Christopher C. Beling, Newark (1948)
Fourth District: S. Emlen Stokes, Moorestown (1948)
Delegates to the A. M. A.:
Andrew F. McBride, Paterson (1947)
Lucius F. Donohoe, Bayonne (1947)
Alternate Delegates to the A. M. A.:
Spencer T. Snedecor, A. U. S. (1947)
Ralph K. Hollinshed, Westville (1947)
Delegate to New York: James F. Norton, Jersey City (1946)
Alternate Delegate to New York: D. Ward Scanlan, Atlantic City (1946)
Delegate to Connecticut: Alfred Stahl, Newark (1946)
Alternate Delegate to Connecticut: William G. Herrman, Asbury Park (1946)
Publication Committee: Henry C. Barkhorn, Newark (1948)
Scientific Work Committee—
Second District: William W. Maver, Jersey City (1950)

### 1946 Annual Meeting

The place and dates of the 180th Annual Meeting of the State Society were tentatively set for the Claridge Hotel, Atlantic City, Tuesday, Wednesday and Thursday, May 21-23, 1946, upon motion by Dr. Stahl, second by Dr. North and unanimously carried.

### Introduction of Second Vice-President

Dr. J. Howard Hornberger of Roebling, newly elected Second Vice-President, was introduced to the gathering by President Londrigan.

### Inauguration of President

Dr. Londrigan, retiring President, thanked the members of the Board, the Officers and Committees for their diligent work and cooperation during his administration, and presented the incoming President, Dr. Samuel Alexander of Park Ridge.

Dr. Alexander's inaugural address appears on page 205 in this issue of *The Journal.*

### Vote of Thanks

A rising vote of thanks was given Dr. Londrigan for the time and effort he devoted to the State Society during his administration.

### Adjournment

Upon motion, duly seconded and carried, the meeting adjourned at 12:30 p. m.

Alfred Stahl, M.D.,
*Secretary.*

# WOMAN'S AUXILIARY
to
# THE MEDICAL SOCIETY OF NEW JERSEY

## I. PRE-SESSION BOARD MEETING

MRS. BANKS S. BAKER, Recording Secretary, Camden, N. J.

The Pre-Session Board Meeting of the Woman's Auxiliary to The Medical Society of New Jersey was held in the West Room of the Claridge Hotel, Atlantic City, on May 22, 1945, at 4:00 p. m. at the call of the President, Mrs. David B. Allman.

The following members responded to roll call:

Mrs. Gerald E. McDonnel, Mrs. Richard J. McDonald, Mrs. J. Howard Hornberger, Mrs. Asher Yaguda, Mrs. David B. Allman, Mrs. Banks S. Baker, Mrs. Thomas P. McConaghy, Mrs. Daniel C. Reyner, Mrs. James H. Mason, Mrs. Samuel Alexander, Mrs. Chester I. Ulmer, Mrs. Frederick G. Wandall, Mrs. Max L. Weimann, Mrs. Don A. Epler, Mrs. Lodovico Mancusi-Ungaro, Mrs. R. J. Faulkingham, Mrs. H. D. Cowlbeck, Mrs. Charles F. Merrill.

The minutes of the March meeting were approved as read.

The Treasurer's statement was presented by Mrs. T. P. McConaghy and ordered filed for audit.

The Corresponding Secretary, Mrs. Daniel C. Reyner, read the following communications:

1. A letter from Mrs. Hubbard, regarding the inactivity of Union County. Mrs. Hubbard regretted her inability to attend the meeting and expressed her best wishes for a successful meeting.

2. A letter from Miss Wolfe, Executive Secretary of the Woman's Auxiliary to the American Medical Association, regarding the cancellations of Annual Meetings due to the regulations of the Office of Defense Transportation.

Mrs. Allman requested the Recording Secretary to take the chair during the presentation of the President's Report.

### PRESIDENT'S (Pre-Board Meeting) REPORT
### March 12 to May 22, 1945

MRS. DAVID B. ALLMAN, Atlantic City, N. J.

Since our last Board Meeting, held in Trenton on March 12th, I have had the pleasure of visiting several additional component County Auxiliaries, and attending their meetings.

On March 13th I was the guest of the Monmouth County Auxiliary. Mrs. William E. Dodd and Mrs. Howard Hornberger accompanied me on that occasion. A very fine luncheon was served and the meeting was interesting. This Auxiliary is now interested in a new project—a "Blood Transfusion Fund"—and I believe that this project will act as a "transfusion" for the Society and that their position and condition will improve.

Since our last Board Meeting, I have attended three Public Relations meetings in this State, and one in Philadelphia. Camden County had its meeting on March 20th, Essex County on April 9th, and Gloucester County on April 26th. The Philadelphia meeting was held on April 10th. All of these meetings were most interesting and instructive, and all were well attended. The Counties sponsoring these meetings are indeed to be congratulated.

On April 17th I was the guest of Warren County. This County holds a combined luncheon with the Medical Society of Warren County. The idea is a splendid one. I am happy to have been their guest on that occasion.

On May 1st I was the guest of Camden County at their Annual Meeting, installation of officers and luncheon. They had a most enjoyable program and I was indeed happy to have been there.

During the period covered by this report, the work of the Office of President proceeded in a routine manner, and because of the absence of friction, Auxiliary affairs have progressed with a minimum of heat and a maximum of efficiency.

Mrs. Epler moved that the President's Report be accepted with thanks. Seconded and carried.

Reports were submitted by the Chairmen of the following committees:

Finance—Mrs. Chester I. Ulmer
Legislation—Mrs. Max L. Weimann
Nominations—Mrs. Asher Yaguda
Organization—Mrs. J. Howard Hornberger
Press and Publicity—Mrs. L. Mancusi-Ungaro

The Acting Credentials Chairman submitted the following report: 4 Advisory Board, 4 Executive Board, 2 Directors, 11 Committee Chairmen, 5 County Presidents, 1 Honorary Member, 7 guests, a total of 26 present.

Mrs. McConaghy moved that these reports be accepted. Seconded and carried.

Reports were submitted by the Presidents of the following Counties:

Atlantic—Mrs. Daniel C. Reyner
Camden—Mrs. T. P. McConaghy
Essex—Mrs. Mancusi-Ungaro
Mercer—Mrs. H. D. Cowlbeck
Middlesex—Mrs. Charles F. Merrill

Mrs. McDonald moved that these reports be accepted. Seconded and carried.

Mrs. Mancusi-Ungaro, who represented the Auxiliary at the Newark Safety Council, submitted her report. Mrs. Allman thanked Mrs. Mancusi-Ungaro for her splendid work and discharged this committee.

Mrs. Allman advised that we have received a check from Mrs. Flint, Treasurer of Somerset County; however, Mrs. Flint made no explanation and failed to reply to Mrs. Allman's inquiry regarding the money.

The President appointed Mrs. Gerald E. McDonnel and Mrs. Daniel C. Reyner to serve on the Auditing Committee.

Mrs. Asher Yaguda presented the revised convention procedure and moved its adoption. Seconded by Mrs. Weimann and carried.

### Announcements

Mrs. Allman announced that the Fellowettes' dinner would be held at 7:00 p. m. in the East Room.

The President advised that Mrs. Dodd is quite ill and will not be able to attend the dinner.

There being no further business, the meeting adjourned.

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## II. THE EIGHTEENTH ANNUAL MEETING

Mrs. Banks S. Baker, Recording Secretary, Camden, N. J.

The 18th Annual Meeting of the Woman's Auxiliary to The Medical Society of New Jersey was held in the West Room of the Claridge Hotel, Atlantic City, on Wednesday, May 23, 1945, at 9:30 a. m., at the call of the President, Mrs. David B. Allman.

The invocation was given by Rev. Harvey Bennett of the First Presbyterian Church of Atlantic City.

The address of welcome was given by Mrs. Daniel C. Reyner, President of the Woman's Auxiliary to the Medical Society of Atlantic County. The response was made by Mrs. Emanuel Sickle of Ocean County.

Memorial Service was conducted by Mrs. H. Roy Van Ness, Past President, for the following deceased members:

Mrs. Kirk B. Barb, Camden County
Mrs. Edna Dodson, Hudson County
Mrs. Leonard L. Friedmann, Mercer County
Mrs. Frank W. Ash, Passaic County
Mrs. Irwin H. Hance, Ocean County

Mrs. Don A. Epler, Parliamentarian, read the Rules and Procedure for the meeting and moved their adoption. Seconded and carried.

The President appointed Mrs. A. J. Casselman to act as Timekeeper.

Mrs. McDonnel moved that the minutes of the 17th Annual Meeting be approved as printed. Seconded and carried.

Mrs. T. P. McConaghy, Treasurer, submitted her report for the year 1944-1945. Mrs. G. E. McDonnel, Chairman of the Auditing Committee, reported that the Treasurer's books had been audited and found correct. Mrs. Asher Yaguda moved that the Report of the Treasurer, together with the attestation of the Auditing Committee, be accepted and filed. Motion was seconded and carried.

Mrs. Allman requested the Recording Secretary to take the chair during the presentation of the President's Report. (See page 246.) Mrs. Van Ness moved that the Report of the President be accepted with thanks. Seconded and carried.

### Reports of Officers and Committee Chairmen

Mrs. Hornberger moved that the Reports of Officers and Committee Chairmen be accepted as a whole. Seconded and carried.

Reports were submitted by the following Officers and Committe Chairmen:

Corresponding Secretary—Mrs. Daniel C. Reyner
Entertainment—Mrs. James H. Mason
Finance—Mrs. Chester I. Ulmer
Hygeia—Mrs. Frederick G. Wandall
Legislation—Mrs. Max L. Weimann
Organization—Mrs. J. Howard Hornberger
Parliamentarian—Mrs. Don A. Epler
Press and Publicity—Mrs. L. Mancusi-Ungaro
Program—Mrs. R. J. McDonald
War Participation—Mrs. G. E. McDonnel
Archives and Historian—Mrs. C. C. Chianese

Mrs. Yaguda moved that we accept the Reports of Officers and Chairmen with thanks. Seconded and carried.

### REPORTS OF COUNTY PRESIDENTS

Mrs. R. J. McDonald moved that we accept the Reports of County Presidents as a whole.

Reports were submitted by the following County Presidents:

Atlantic—Mrs. Daniel C. Reyner
Camden—Mrs. T. P. McConaghy
Essex—Mrs. L. Mancusi-Ungaro
Gloucester—Mrs. Diverty (read by Mrs. Ulmer)
Mercer—Mrs. H. D. Cowlbeck
Middlesex—Mrs. C. F. Merrill
Ocean—Mrs. William E. Dodd (read by Mrs. Sickle)

Mrs. McDonald moved that we accept the Reports of County Presidents. Seconded and carried.

### NEW BUSINESS

Mrs. Allman advised that she had received a card from Dr. Way saying that they would like to re-organize Cape May County Auxiliary.

### ELECTION OF NOMINATING COMMITTEE

In accordance with Chapter I, Section 1 of the By-Laws, the following members were nominated to serve on the Nominating Committee, of which Mrs. David B. Allman will be Chairman:

Mrs. R. J. Faulkingham
Mrs. Daniel C. Reyner
Mrs. George Rogers
Mrs. A. J. Casselman

Mrs. McDonnel moved that the nominations be closed and that the Recording Secretary be instructed to cast the unanimous ballot for the election of these members. Motion was seconded and carried.

The Recording Secretary cast the ballot and this Committee was declared duly elected.

### REVISIONS

Mrs. Andrew C. Ruoff presented Revisions to the By-Laws and moved that they be adopted and printed. Seconded by Mrs. McDonnel and carried.

Mrs. Allman appointed Mrs. H. Roy Van Ness, Mrs. F. G. Wandall and Mrs. C. C. Chianese to serve in addition to the present Committee consisting of Mrs. Epler, Mrs. G. E. McDonnel with Mrs. Ruoff as Chairman.

### RESOLUTIONS

Mrs. R. J. Faulkingham presented the following resolution:

Resolved, That the Officers and County Presidents of the Woman's Auxiliary to The Medical Society of New Jersey extend their thanks to Mrs. David B. Allman, President of the Auxiliary, and her general chairman for the careful handling of every detail for the comfort and happiness of the Officers, that the Corresponding Secretary be instructed to express appreciation to Mr. Gerald Trimble, Manager of the Claridge Hotel, for the courtesies shown the Auxiliary.

Mrs. Faulkingham moved the adoption of this resolution. Seconded and carried.

The meeting adjourned for luncheon and reconvened at 2:45 p. m.

The President appointed the following members to serve on the Reading Committee:

Mrs. A. J. Casselman, Chairman
Mrs. Chester I. Ulmer
Mrs. G. E. McDonnel

### ELECTION OF OFFICERS

Mrs. Asher Yaguda, Chairman of the Nominating Committee, presented the following slate:

President-Elect—Mrs. Frederick G. Wandall, Clayton
First Vice-President—Mrs. Lodovico Mancusi-Ungaro, Newark
Second Vice-President—Mrs. Floyd A. Shimer, Phillipsburg
Recording Secretary—Mrs. Banks S. Baker, Camden
Treasurer—Mrs. Thomas P. McConaghy, Camden
Directors:
Mrs. C. Chester Chianese, Trenton
Mrs. Robert B. Walker, New Brunswick

Mrs. Hornberger moved that the nominations be closed and that the Recording Secretary cast the unanimous ballot. Motion was seconded and carried.

The Recording Secretary cast the ballot and the President declared the above named officers duly elected.

### INSTALLATION OF OFFICERS

The President, Mrs. David B. Allman, installed the newly elected officers and presented the gavel to Mrs. Mancusi-Ungaro, First Vice-President, in the absence of Mrs. William E. Dodd, who is ill.

Mrs. Mancusi-Ungaro accepted the gavel for Mrs. Dodd.

Mrs. Allman presented Dr. William E. Dodd, Chairman of the Advisory Committee to the Woman's Auxiliary. Dr. Dodd congratulated the Auxiliary on the work we have done and thanked us on behalf of the Medical Society.

The President read a letter from Mrs. Dodd expressing her regrets at not being able to attend the meeting.

The final Report of the Credentials Chairman was submitted by Mrs. Cottone.

Mrs. Mancusi-Ungaro read Mrs. Dodd's acceptance speech and announced that the Post-

Session Board meeting would be held immediately following this meeting rather than at four o'clock.

There being no further business the President declared the 18th Annual Meeting adjourned.

## III. ANNUAL REPORT OF THE PRESIDENT

Mrs. David B. Allman, Atlantic City, N. J.

I am indeed happy to report to you that the past year has been a most successful one for your Auxiliary. Not only have we gained numerically during 1944-45, but we have also gained in prestige.

No President of this Auxiliary has ever had finer coöperation from all interested in Auxiliary matters, and this is reflected in the splendid accomplishments of the past year.

We now have a total membership of eight hundred and ninety-seven; an increase of fifty-five members. Fourteen counties in the State have organized Auxiliaries.

During my year we have had three Executive Board Meetings in Trenton and one in Atlantic City. All were well attended. One conference was also held at the Executive Offices in Trenton.

In spite of the O. D. T. and the hardships of travel, I have made eleven official visits to County Auxiliaries, and have attended four Public Relations Meetings.

As some of you may have noticed in *The Journal* of The Medical Society under the caption "Woman's Auxiliary", there have been published nine articles entitled "President's Message".

A conference of Presidents and Presidents-Elect was held in Chicago by the Woman's Auxiliary to the American Medical Association, which I attended.

A report has been sent to "National" for publication.

The one "off note" in this report is the fact that only thirty-two of our members subscribe to the *Bulletin*. This is a deplorable situation. Every Auxiliary member who is truly interested in Auxiliary affairs should subscribe to this publication. The price is reasonable, and the *Bulletin* is newsworthy. I plead for more subscriptions this coming year.

Our Historian has compiled from the County Histories a very complete record of each county's activities for the year 1944-45, this being the History of the eighteenth year of the Woman's Auxiliary to The Medical Society of New Jersey.

*Hygeia* has been well promoted and is now being distributed to doctors' offices, hospitals, schools, public libraries, etc. There is still much to be desired, however, in our participation in this work. Only two of our Counties went over their "quotas", and we as an Auxiliary can only claim one hundred and fifty-five subscribers through our efforts. This publication is not only a "health magazine" but it is also of a promotional nature, causing a better understanding by the laity of the workings of organized medicine. Its distribution should be further encouraged.

Your Public Relations Committee has been active throughout the State. Reciprocity Teas were held in several counties. Public meetings were held on such vital subjects as Medical-Surgical Plan of New Jersey, the Wagner-Murray-Dingell Bill, Cancer Control, etc.

In addition to the program outlined at the beginning of my term of office, several Counties are working on other worth-while projects such as a "Rheumatic Heart Foundation", Blood Bank funds, raising money for hospitals, etc.

Two of our State Executive Board Meetings were devoted to legislative programs. At one Dr. Frederic J. Quigley spoke on federal and state legislation, and at the other, Dr. Norman Scott presented the "Medical-Surgical Plan of New Jersey". Our State Committee has kept you informed of the various legislative problems which confront organized medicine.

Our War Service Committee has been a most active one. Five hundred and seventy-three of our members have given 70,808 hours of voluntary service in various categories, and $173,569.00 worth of War Bonds and Stamps have been sold. I feel that you women who participated in this fine work are indeed to be commended.

I believe that another precedent has been established during the past year, that cannot help but reflect in the good work that we are doing. Your President-Elect, Mrs. William E. Dodd, has accompanied me on all of my official visits, and has also attended the Public Relations meetings with me. Would that I had had such a splendid opportunity to learn the workings of this office from the "sidelines". I was of course most happy to have Mrs. Dodd with me—and the experience that she has had cannot but help make her a more efficient President during the coming year. I wish to highly recommend this procedure for the good of the organization.

In closing, I wish to thank all those who have served me so faithfully and so well during my administration. The honor of being President of this Auxiliary is not without its headaches and its heartaches—but these are more than compensated by the splendid spirit of coöperation and the loyal support given me by all.

I wish to particularly thank the Chairman of the Advisory Committee to the Woman's Auxiliary, the Officers and Trustees of The Medical Society of

New Jersey, Mrs. Edith L. Madden, Acting Executive Officer of The Medical Society of New Jersey, and her efficient staff, my fellow Officers, my Executive Board, the County Presidents, and each and every member who has helped to make this past year a highly successful one in the history of the Woman's Auxiliary to The Medical Society of New Jersey.

## IV. TREASURER'S REPORT

### WOMAN'S AUXILIARY TO THE MEDICAL SOCIETY OF NEW JERSEY

MRS. THOMAS P. MCCONAGHY, Treasurer, Camden, N. J.

| | | Emergency | General | Total |
|---|---|---|---|---|
| April 26, 1944, Balance on hand | | $292.05 | $349.17 | $641.22 |
| RECEIPTS | | | | |
| Convention expenses of National President Mrs. Carey returned | $ 16.00 | | | |
| Dues for counties | 488.40 | | | |
| Hudson County excess to be returned | .95 | | | |
| Sale of 12 Hand Books | 3.00 | | | |
| Sale of Index cards | 7.65 | 48.91 | 467.09 | 516.00 |
| | | $340.96 | $816.26 | $1157.22 |
| DISBURSEMENTS | | | | |
| Mrs. Yaguda, President's expenses 1943-1944 | $ 20.98 | | | |
| Expenses—Legislative Chairman, 1943-1944 | 6.95 | | | |
| Entertainment Chairman expenses 1943-1944 | 12.50 | | | |
| National President, Mrs. Carey, expenses | 16.00 | | | |
| Expenses to A. M. A.—Mrs. Yaguda | 100.00 | | | |
| Expenses to A. M. A.—Mrs. Allman | 100.00 | | | |
| One $100 War Bond | 74.00 | | | |
| 24 Hand Books | 6.00 | | | |
| Stationery | 20.25 | | | |
| 2000 Index cards | 18.75 | | | |
| Mrs. Allman, President, expenses | 82.22 | | | |
| Treasurer's Bond | 5.00 | | | |
| Dues, N. J. Health and Sanitary Association | 3.00 | | | |
| Expenses—Publicity Chairman | 5.51 | | | |
| Expenses—Treasurer | 4.00 | | | |
| Expenses—Finance Chairman | 3.00 | | | |
| Expenses—Hygeia Chairman | 3.00 | | | |
| Expenses—War Participation Chairman | 1.37 | | | |
| National Treasurer, 875 current dues | 218.75 | | | |
| President's Pin | 32.00 | | 733.28 | 733.28 |
| | | $340.96 | $ 82.98 | $423.94 |
| Transfer of cost of 2 $100 War Bonds from General to Emergency Account | | 148.00 | 148.00 | |
| May 23, 1945, Balance on hand | | $192.96 | $230.98 | $423.94 |

Plus investments on hand of Two $100 Series F U. S. War Bonds due in 12 years, serial 4C742366F issued September, 1943, and serial C1065402F issued June, 1944, to the Woman's Auxiliary to The Medical Society of New Jersey.

## V. POST-SESSION BOARD MEETING

MRS. BANKS S. BAKER, Recording Secretary, Camden, N. J.

The Post-Session Board Meeting of the Woman's Auxiliary to The Medical Society of New Jersey was held in the West Room of the Claridge Hotel on Wednesday, May 23, 1945, at 3:30 p. m., at the call of Mrs. Lodovico Mancusi-Ungaro, First Vice-President.

The following members responded to the roll call:

Mrs. R. J. McDonald, Mrs. J. Howard Hornberger, Mrs. Asher Yaguda, Mrs. David B. Allman, Mrs. Frederick G. Wandall, Mrs. Lodovico Mancusi-Ungaro, Mrs. Banks S. Baker, Mrs. T. P. McCon-

aghy, Mrs. Emanuel Sickle, Mrs. James H. Mason, Mrs. Andrew C. Ruoff, Mrs. Samuel Alexander, Mrs. C. C. Chianese, Mrs. Harry D. Cowlbeck, Mrs. Chester I. Ulmer, Mrs. M. L. Weimann, Mrs. Don A. Epler, Mrs. G. E. McDonnel, Mrs. C. F. Merrill, Mrs. Robert Bradley.

The minutes of the Pre-Session Board Meeting were approved as read.

The Treasurer's statement was received for audit.

Mrs. Mancusi-Ungaro introduced Mrs. Frederick G. Wandall, President-Elect.

Mrs. Mancusi-Ungaro announced the committee appointments and introduced the Chairmen present.

Mrs. Ruoff, Chairman of Revisions, advised that a meeting of her committee had been called in June.

Mrs. Ulmer moved that when the revisions to the By-Laws are completed, the committee be given permission to have them printed or mimeographed. Motion was seconded by Mrs. Yaguda and carried.

Mrs. McDonald moved that we ask Mrs. Dodd to call a conference at her convenience some time toward the end of June to instruct the officers of the component counties in carrying out their duties. Motion was seconded by Mrs. McDonnel and carried.

Mrs. McConaghy moved that a letter be written by the President, Mrs. William E. Dodd, to the Presidents of the County Auxiliaries informing them that one of their first duties is to file a complete list of officers and members together with addresses with the Executive Office in Trenton not later than July 1. Motion was seconded and carried.

Mrs. Mancusi-Ungaro announced that the first regular meeting of the Board will be held on Monday, October 8.

There being no further business the meeting adjourned.

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## VI. ATTENDANCE

Following is the attendance for the 1945 Annual Meeting:

| | | |
|---|---|---|
| Advisory Board | 4 | |
| Executive Board | 4 | |
| Directors | 2 | |
| State Chairmen of Committees | 9 | (5)* |
| County Presidents | 2 | (3)* |
| | 21 | |

* Included in Advisory Board, Executive Board and Directors count.

# TUBERCULOSIS ABSTRACTS

*A Review for Physicians*

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

**Vol. XVIII** **July, 1945** **No. 7**

THAT diabetics are prone to acquire tuberculosis is not a new observation, but present-day circumstances have given it a new importance. If the opportunity for effective treatment of tuberculosis is not to be lost, this sinister association must be kept in mind by the doctor. The way to safety lies in considering the possibility that tuberculosis may be now, or at any time may become, a complicating factor with every case of diabetes.

## DIABETES AND TUBERCULOSIS

The significance of the association of diabetes and tuberculosis is accentuated by the continued rise in the frequency of diabetes and the increase in the incidence of pulmonary tuberculosis in persons with diabetes in spite of the decline in the tuberculosis mortality rate in the general population.

Reports from American clinicians made over a period of years indicate that tuberculosis occurs four times as frequently in diabetic persons as in the general population. The age of the diabetic patient is important. One study in Massachusetts showed that tuberculosis was more than 13 times as frequent among those who acquired diabetes before the age of 15 as it was among a corresponding group of school children, while among adolescent diabetic patients the incidence was 16 times as great as in a corresponding high school group.

Several theories have been proposed to account for the predisposition of diabetic persons to tuberculosis. Of these the one which the evidence seems to favor is that Vitamin A deficiency plays a part. Since a Vitamin A deficiency usually occurs in the presence of diabetes, this lack may explain in a large measure the increased susceptibility of diabetic patients to tuberculosis. Lack of Vitamin A causes specific pathologic changes in the mucosa of the respiratory system which favor the invasion of bacteria into the lung and bronchial tissues.

A wide discrepancy exists between the estimated number of cases of diabetes associated with tuberculosis and the number of such patients who are admitted to tuberculosis hospitals. Failure to hospitalize these patients in specialized institutions carries serious implications relating to the welfare of the patient and to the public health. The reasons for this failure may be (1) lack of diagnostic consciousness, (2) improper interpretation of symptoms, (3) incomplete diagnostic investigation, (4) asymptomatic forms of pulmonary tuberculosis. The higher recovery rate of persons with early tuberculosis as compared to those with advanced tuberculosis justifies a plea for an early diagnosis of this condition in diabetic patients.

Experience has shown that the best attitude is to anticipate the possibility of tuberculosis as a complication. A tuberculin test should be given to all persons with diabetes. This test should be repeated annually as long as it is negative. For those who react positively to tuberculin there should be a chest roentgenogram every year at least. Examination of the sputum should be carried out for all patients with a productive cough and if the roentgenogram of the chest indicates reason for suspicion, fasting stomach contents should be aspirated five successive times and examined by culture or by the inoculation of guinea pigs.

The percentage of diabetic patients entering the tuberculosis hospitals with minimal tuberculosis seems to be unduly low and may be attributed to a lack of diagnostic suspicion on the part of the physician treating the diabetes. The emphasis formerly placed on the lack of subjective symptoms of diabetic patients with active pulmonary tuberculosis is no longer valid since mass X-ray surveys have revealed that asymptomatic tubercu-

losis also exists among nondiabetics. Several authors have observed that cavitation is frequent when pulmonary tuberculosis is complicated by the presence of diabetes. Other complications except that of spontaneous pneumothorax occur less frequently than they do in nondiabetic patients with tuberculosis.

The management of diabetes in the presence of tuberculosis has evolved with the trend in diabetic treatment. In the authors' experience it was found that in patients, who were given a well planned diet and adequate amounts of insulin, slight glycosuria and hyperglycemia not exceeding 200 mg per hundred cubic centimeters are compatible with favorable therapeutic response as far as pulmonary tuberculosis is concerned. Improvement in the pulmonary condition of patients belonging to this group compares favorably with that recorded for tuberculous patients whose blood sugar was kept on a practically normal level.

Although it may appear heretical in the treatment of tuberculosis the authors are of the opinion that reducing the diet for overweight diabetic patients with pulmonary tuberculosis is as justifiable and practicable as for nontuberculous obese persons with diabetes. The administration of massive doses of Vitamin A from 150 thousand to 200 thousand U.S.P. units daily may serve as a useful adjunct in the management of diabetes mellitus complicated by pulmonary tuberculosis.

The indications and contraindications for collapse therapy are the same for diabetic as for nondiabetic tuberculous patients. Because of the frequency with which empyema complicates artificial pneumothorax in persons with predominantly exudative and caseous tuberculous lesions of recent origin, the use of this measure is rather limited for tuberculous diabetic patients.

An analysis of the reports of ten American clinicians based on the observations of 17,358 cases of diabetes indicates a higher incidence of tuberculosis in diabetic persons than in the general population of the United States.

The fact that an unusually high percentage of diabetic patients who acquire tuberculosis are not adequately treated for their pulmonary disease before it reaches the far advanced stage calls for an urgent revision of the diagnostic approach to this problem.

During the period covered by this study 115 tuberculous diabetic patients were discharged from Muirdale Sanatorium. On discharge eight of the 17 persons with moderately advanced pulmonary tuberculosis were classified as apparently arrested, quiescent or improved, and nine were unimproved or had died. Of the 96 persons in the far advanced group 14 reached the stage where their disease was apparently arrested, quiescent or improved, while 82 individuals remained unimproved or died. These therapeutic results are less favorable than those recorded for nondiabetic patients with moderately advanced and far advanced pulmonary tuberculosis.

*Diabetes and Tuberculosis (with a review of the literature), Andrew L. Banyai, M.D., and Anthony V. Cadden, M.D., Archives of Internal Medicine, December, 1944.*

SUPPLIED BY

NEW JERSEY TUBERCULOSIS LEAGUE

15 East Kinney Street, Newark 2, New Jersey




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# SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

# PRESCRIPTION PHARMACISTS

TO THE MEMBERS OF

## THE MEDICAL SOCIETY OF NEW JERSEY

| Place | Name and Address | Telephone |
|---|---|---|
| AUDUBON | Tegeler's Drug Store, Ellis Bulk, Prop. 315 Atlantic Ave. | Audubon 1037 |
| BAYONNE | Nelson W. Dittmar, 924 Broadway | Bayonne 3-0406 |
| BLOOMFIELD | Burgess Chemist, 56 Broad St. | BLoomfield 2-1006 |
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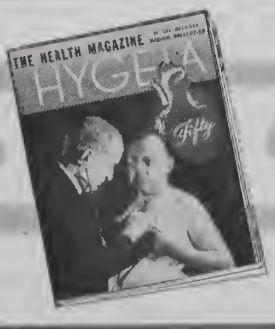
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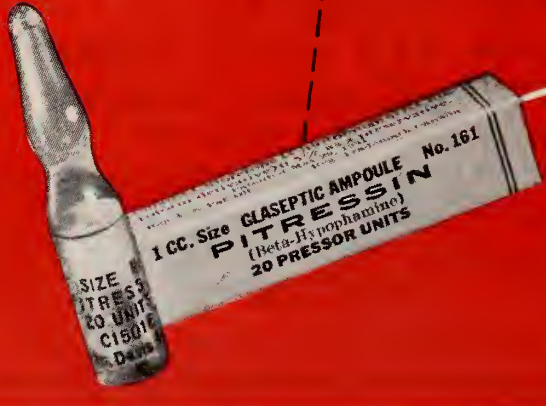
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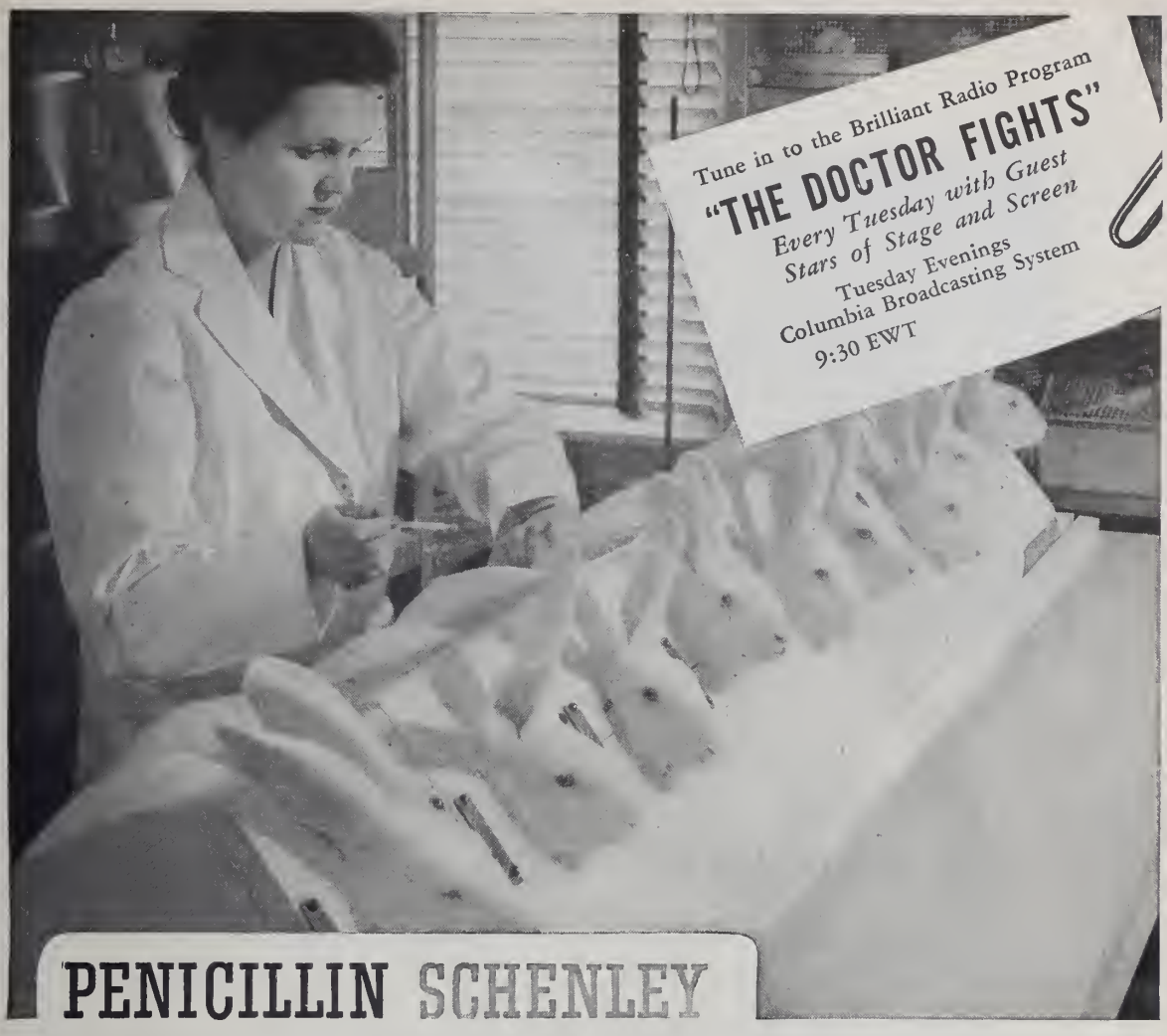
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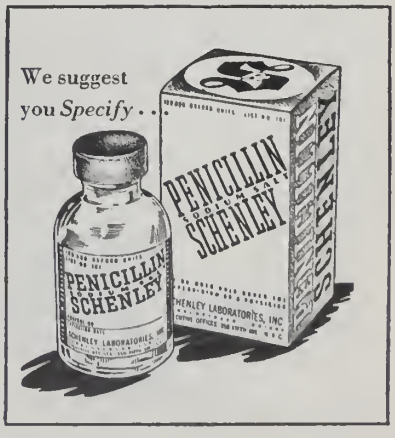



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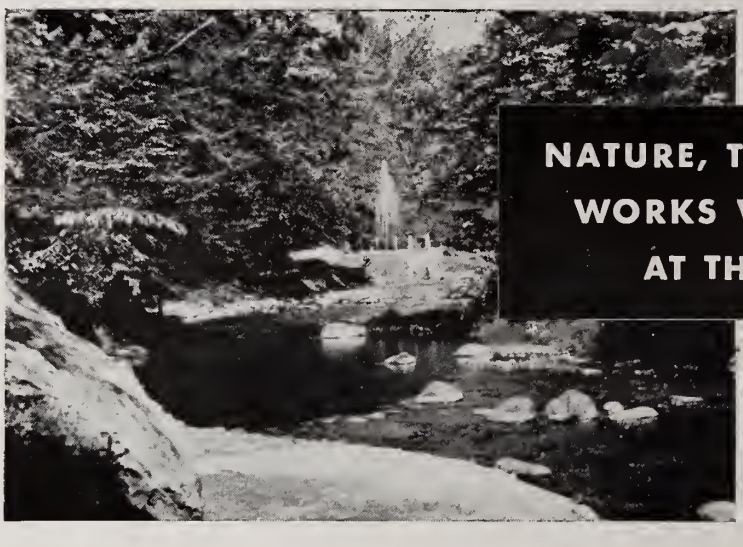
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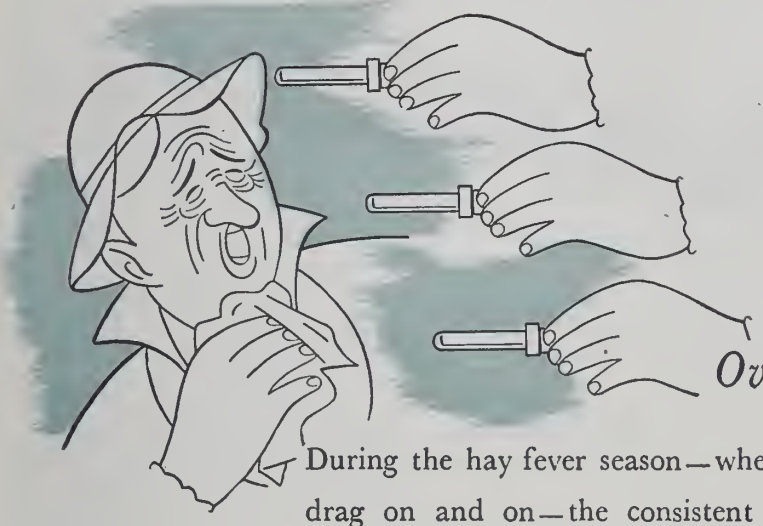
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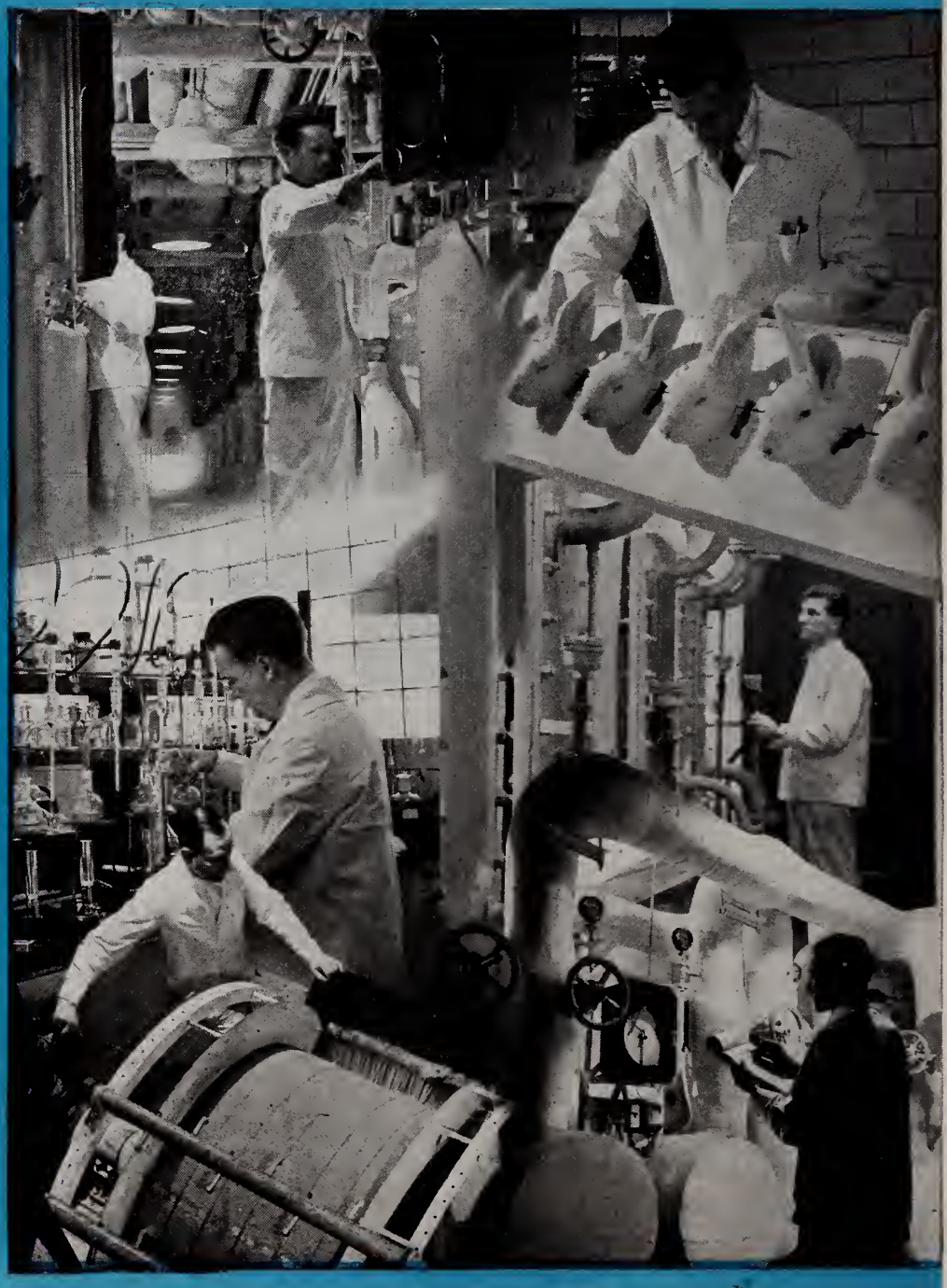
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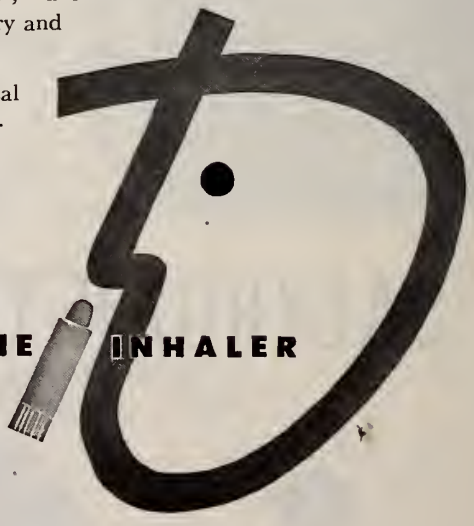
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Feinberg, S.M.: Allergy in Practice, The Year Book Publishers, Inc., Chicago, 1944, "Hay Fever Treatment."

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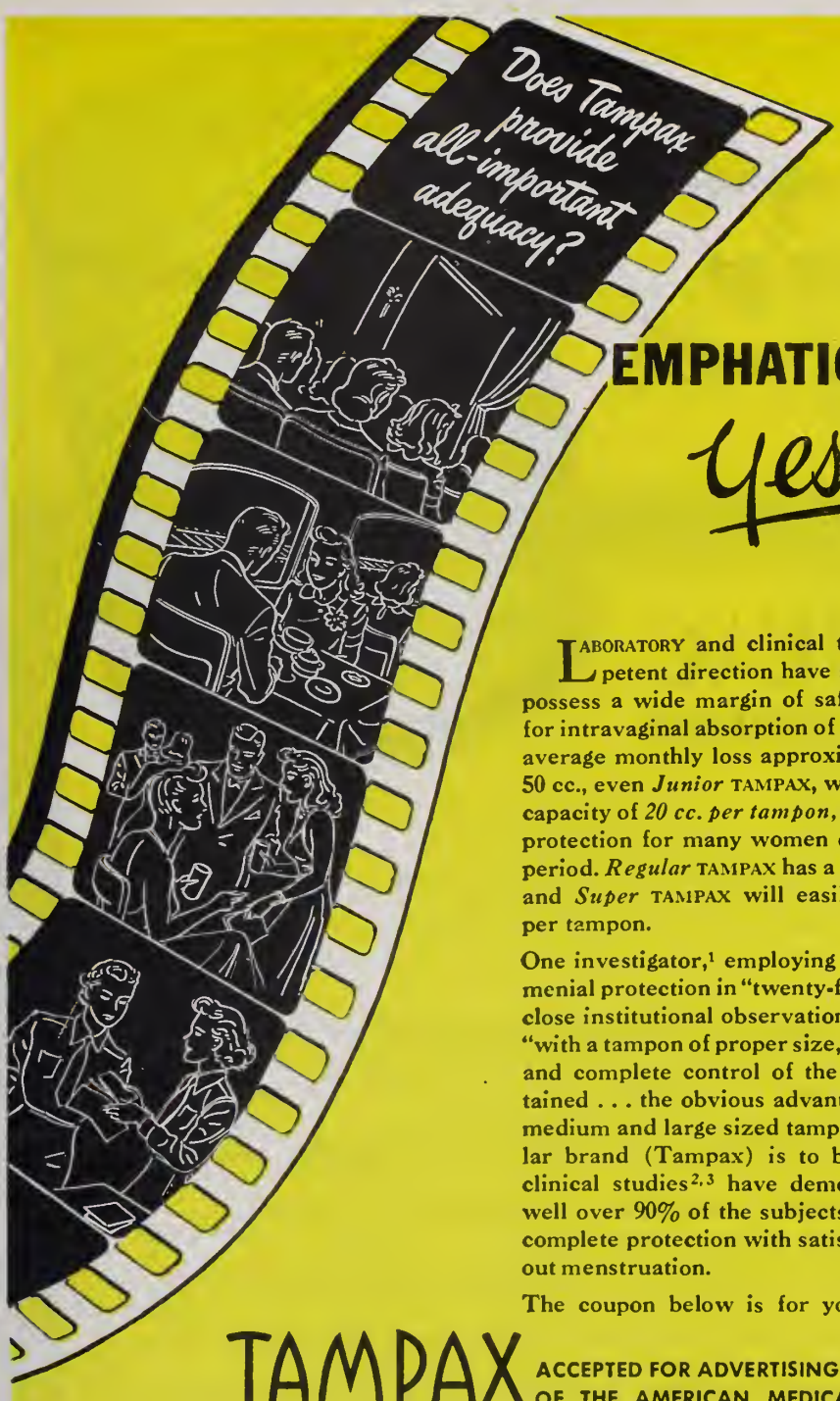
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REFERENCES: 1. Med. Rec., 155:316, 1942. 2. West. J. Surg., Obst. & Gynec., 51:150, 1943. 3. Clin. Med. & Surg., 46:327, 1939.

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1. Coburn, A. F.: Salicylate Therapy in Rheumatic Fever, Bull. Johns Hopkins Hosp. 73: 435-464 (Dec.) 1943.
2. Smull, K., Wégria, R., and Leland, J.: The Effect of Sodium Bicarbonate on the Serum Salicylate Level, J.A.M.A. *125*: 1173 (Aug. 26) 1944.
3. New and Nonofficial Remedies, 1943, p. 57.


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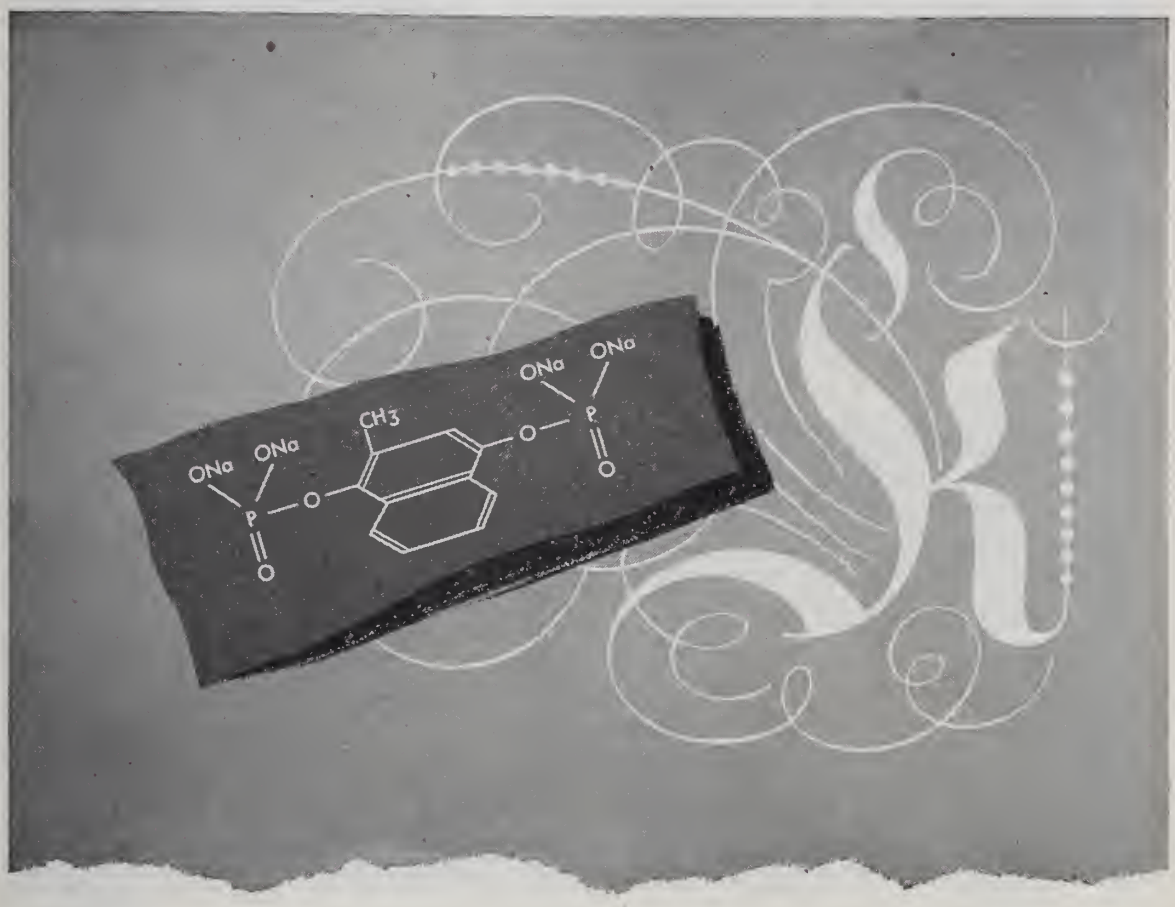
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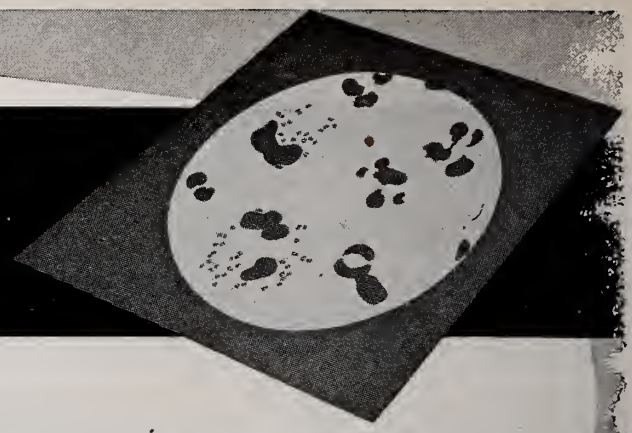
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THOUGH the sulfonamides presented a signal advancement in the treatment of gonorrhea, many published reports indicate that penicillin is the therapeutic agent of choice for three potent reasons. First, *efficacy:* penicillin proves effective in virtually all instances. Second, *safety:* penicillin is practically nontoxic. Third, *brevity of treatment:* in the majority of cases, definite cure can be effected in 24 to 48 hours.

Studies at an Army Station Hospital showed that most sulfonamide-resistant gonococci are fully susceptible to penicillin; that penicillin resistance is difficult to establish.

*Frisch, A. W.; Behr, B.; Edwards, R. B., and Edwards, M. W., Am. J. Syph., Gonor., & Ven. Dis. 28:527 (Sept.) 1944.*

From a study of 109 patients, the conclusion is drawn that penicillin effectively eradicates chemoresistant gonorrhea in the female.

*Greenblatt, R. B., and Street, A. R., J. A. M. A. 126:161 (Sept. 16) 1944.*

At a U. S. Naval Hospital, 200 cases of sulfonamide-resistant gonorrhea treated with penicillin, showed no toxic reactions; all returned to duty in one-third of the time previously required.

*Scarcello, N. S., New England J. Med. 231:609 (Nov. 2) 1944.*

"In the Technical Bulletin of Medicine, No. 26, recently issued by the War Department, penicillin is stated to be the drug choice in the treatment of gonorrhea."

*J. A. M. A. 126:575 (Oct. 28) 1944.*

191 consecutive cases of sulfonamide-resistant gonorrhea responded dramatically to penicillin.

*Wigh, R., and Geer, G. I. Jr., J. Maine M. A. 35:207 (Nov.) 1944.*

No toxic effects were observed in a series of sulfonamide-resistant gonorrhea of the female treated with penicillin. As compared to hyperpyrexia, penicillin treatment "is incomparably easier, simpler, safer, cheaper, and just as effective."

*Barringer, E. D.; Strauss, H., and Horowitz, E. A., N. Y. State J. Med. 45:52 (Jan. 1) 1944.*

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For therapy in the physician's office and in the patient's home, the Combination Package of Penicillin-C.S.C. deserves the physician's preference. It provides two rubber-stoppered, aluminum-sealed, serum-type, 20 cc.-size vials, one containing 100,000 Oxford Units of Penicillin-C.S.C., the other 20 cc. of sterile, pyrogen-free physiologic salt solution. Penicillin-C.S.C. is of high purity, as indicated by the small amount of substance required to present 100,000 Oxford Units.

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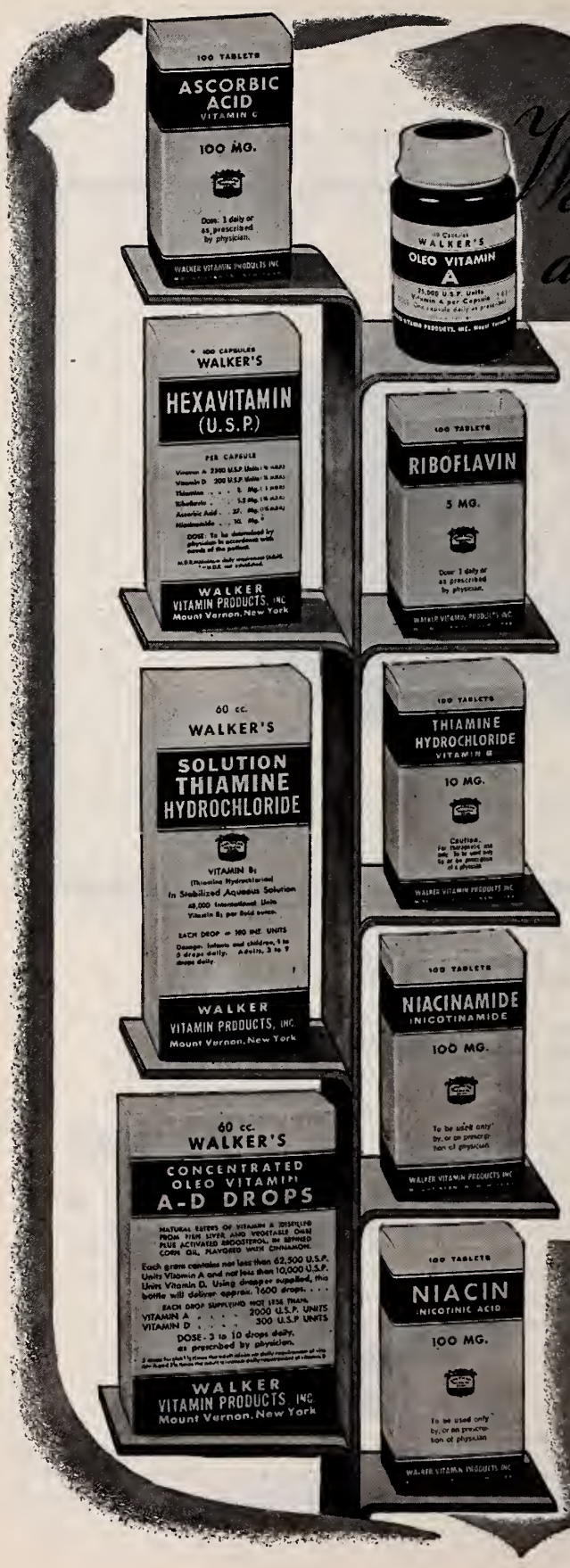
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*Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60
Proc. Soc. Exp. Biol. and Med., 1934, 32, 241
N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592.

TO THE PHYSICIAN WHO SMOKES A PIPE: We suggest an unusually fine new blend—COUNTRY DOCTOR PIPE MIXTURE. Made by the same process as used in the manufacture of Philip Morris Cigarettes.



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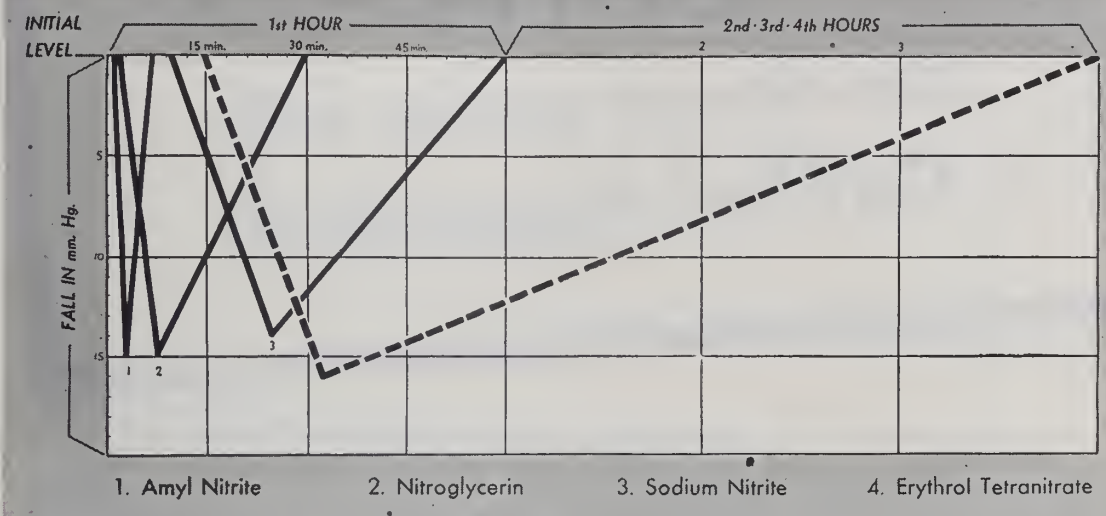
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Treatment of arterial hypertension today is necessarily directed toward relief and not cure. When such measures as rest and dietary control have been unsuccessful, the employment of medical treatment is suggested. Among the various preparations available, Erythrol Tetranitrate offers the advantage of producing a reduction in blood pressure sufficiently prolonged so that administration three times daily may maintain the reduction. Erythrol Tetranitrate Merck may be prescribed over a protracted period with sustained effect. By dilating the peripheral arterioles, it tends to decrease not only the stress of excessive pressure on the arterial walls, but also to relieve the burden of the heart.




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**For Prolonged Vasodilatation in Hypertension**

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That's why the Boston Health Department made the following test, which proved that the purity of Certified-Pasteurized is little short of miraculous:

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|---|---|---|---|---|---|---|---|---|
| | | | ON DELIVERY | 1 DAY AT 40°F. | 2 DAYS AT 40°F. | 3 DAYS AT 40°F. | 4 DAYS AT 40°F. | 5 DAYS AT 40°F. |
| Certified-Pasteurized | 22 | Maximum | 20 | 40 | 100 | 850 | 1000 | 1400 |
| | | Minimum | 0 | 4 | 5 | 8 | 15 | 20 |
| | | Average | 8 | 14 | 44 | 157 | 286 | 770 |

• In discussing this table, the chemists stated that *even after ninety-six hours in the refrigerator*, Certified-Pasteurized still "conformed to the bacterial standards and was perfectly safe for use as measured by present knowledge of the subject."

The report . . . the complete results of which appeared in the *New England Journal of Medicine* . . . was made by the Laboratory for Chemistry and Sanitary Biology, Boston Health Department. If you'd like to have a reprint of the entire study, write to Walker-Gordon, Inc., Plainsboro, N. J.

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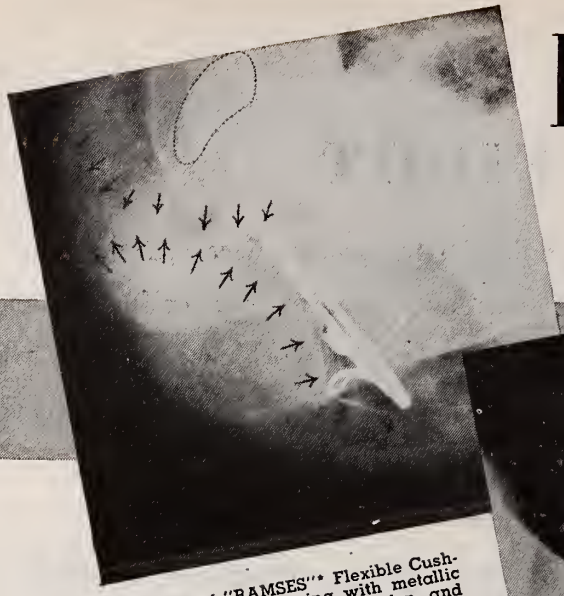
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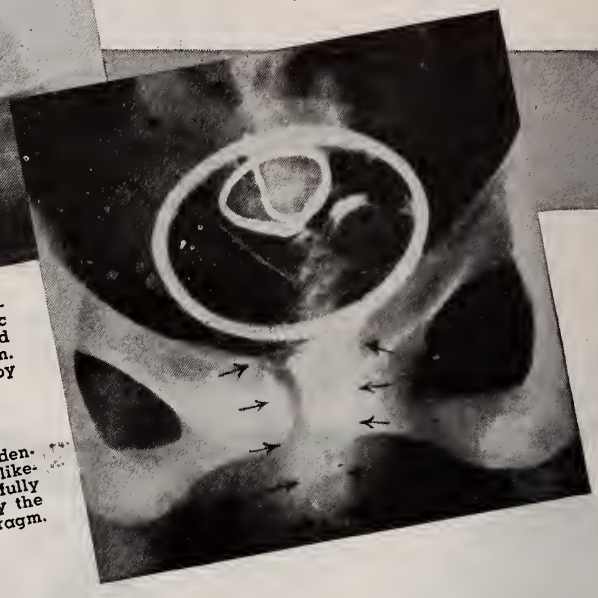
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# Radiography

## CONFIRMS A POINT



Lateral view of "RAMSES"* Flexible Cushioned Diaphragm in vagina with metallic director indicating cervical location and protuberance into the dome of diaphragm. Arrows identify vagina. Area outlined by dotted line represents pubic bone.



"Anteroposterior View". Arrows again identify vagina. Metallic cervical director likewise appears. It is of interest to note fully expanded, circular shape assumed by the "RAMSES" Flexible Cushioned Diaphragm.

Radiographs of the "RAMSES" Flexible Cushioned Diaphragm in position in the vaginal tract show that the proper placement of a diaphragm of the correct size supplies an effective barrier against sperm movement into the cervical canal.

The broad unindented surface of the patented cushioned rim of the "RAMSES" Diaphragm provides a buffer against discomfort from spring pressure on the vaginal walls.

"RAMSES" Flexible Cushioned Diaphragms are manufactured in gradations of five millimeters in sizes from 50 to 95 millimeters inclusive — they are available on the prescription or order of physicians through recognized pharmacies.

Complete literature on "RAMSES" Diaphragms and instructions for proper fitting will be sent to physicians on request.

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## In the severe depressions of the menopause

Many women in the climacteric period develop a true reactive depression, characterized by apathy and despondency.

● This depressive syndrome is frequently progressive; and, unless promptly and effectively treated, may seriously impair the patient's normal capacity for useful living. While estrogenic therapy and other basic treatments can do much to relieve these sufferers, many need further help if a prompt recovery is to be obtained.

● In such cases, Benzedrine Sulfate helps to reawaken mental alertness and optimism, and to restore the savor and zest of life.

● Obviously, Benzedrine Sulfate should not be used for the casual case of low spirits or normal physiologic depression as distinguished from true prolonged mental depression. Smith, Kline & French Laboratories, Philadelphia, Pa.

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THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

PUBLISHED MONTHLY SINCE SEPTEMBER, 1904
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UNDER THE
DIRECTION OF THE
COMMITTEE ON PUBLICATION




HENRY C. BARKHORN, M.D., Chairman

HENRY A. DAVIDSON, M.D., Editor
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# EDITORIALS

## MEDICAL PUBLIC RELATIONS

The objective of the public relations program of our Society is ". . . to secure and retain the good will of the people of New Jersey toward organized medicine in general and toward The Medical Society of New Jersey in particular. . . ." To bring this to a point of accomplishment is one of our major problems and will first require a basic knowledge of what constitutes good public relations.

The recent series of public forums conducted by the Society throughout the State have brought this objective clearly into focus. These forums were worth while if their only accomplishment proves to be the lessons we learned, and the inspiration and stimulation they gave us to study the general problem of public relations, its philosophy and technique.

Good public relations require that we have a thorough knowledge and sincere interest in the problems of our State, our communities, and our social groups; of the daily life problems of individuals and the nation.

Good public relations require an understanding of human relations, human reactions, that we know how other people are thinking and what they are thinking about, that in our own thinking we keep pace with social progress and that we learn to properly interpret public opinion. If we do not develop the ability to do these things, we may meet with abject failure.

Good public relations are not necessarily effective today or tomorrow. It requires a long range program which may show favorable effects years hence, not affecting medicine today or tomorrow but medicine of the future. It requires forward-looking study, research and experiments. Its future effects should point the way for organized medicine if we ever reach the point where we can go no further without changing our direction.

Medical public relations must not be presented from the standpoint of the welfare of the medical profession or the

welfare of the individual physician, but rather from the standpoint of promoting and protecting the welfare of society in general. People are not particularly interested in the problems of the medical profession or in the troubles of the individual physician. Individuals and other groups are primarily interested in their own problems and troubles, and are interested in our problems only as they affect their problems. They will be sympathetic to our efforts only in so far as we convince them that our efforts will assist in the solution of their problems.

Good public relations are not just publicity, newspaper space or advertising. The medical profession has had too much publicity, mostly concerning the advances in scientific medicine and the many dramatic developments in medicine, to the neglect of medicine as represented by the conscientious bag-toting doctor and what he contributes to the welfare of his community.

The most effective factor in good public relations is not the result of a formal public relations program, but the sum-total effect of many small acts performed by individual physicians for the benefit of other individuals or groups, which stimulates among those individuals or groups a sense of respect for the individual physician as a member of the organized profession.

Medicine is now faced with a social and economic problem which we cannot delegate to anybody else for solution. To solve the problem organized medicine must make a contribution which will advance present socio-economic knowledge and we must let general society know of the contribution we are making in their behalf. We must demonstrate our worth to society, that we *are* good, that we *do* good and that what we do accomplish as a free and independent profession is to the best interest of a free society.

---

## THE RIGHT TO EXAMINE HOSPITAL RECORDS IN ACCIDENT CASES

The varying policies of the hospitals of the state as to the examination of hospital records of a person who has sustained personal injuries, or whose death has resulted from personal injuries, have been for many years the cause of great dissatisfaction and injustice to the claimant or to the person against whom a claim is asserted.

Recognition of this fact caused representatives of the State Department of Labor, the New Jersey Hospital Association and the State Bar Association to sponsor a bill (Senate No. 248) at the recent (1945) session of the Legislature to correct the situation. This bill became law May 2nd and is now Chapter 286, Laws of 1945.

The bill is short, and clear in its provisions. It permits the person injured, or his legal representative, "to examine the records of any hospital pertaining to the claim of such injured or deceased person." This right is also accorded to "any person against whom a claim is asserted under the Workmen's Compensation Act, . . . or at law, or his insurance carrier."

Officers or employees of hospitals are not liable for damages for "permitting the examination of such hospitals' records under the provisions of this act".

# THE CHEST X-RAY IN WAR TIME INDUSTRIAL EXAMINATIONS

William L. Bonnet, Capt., M.C., Mercerville, N. J.

Kirklin cited a quotation from Sampson and Brown in his paper pleading for wider employment of the Roentgen rays in lung examinations as follows:

"Today we have progressed to the stage when we call no man sound pulmonically until his stereoscopic roentgenograms have been found to be normal, and consider the roentgenologic study as much a part of the routine examinations of the lungs as the stethoscope, or indeed, as the examination of the sputum." [1]

With this self-explanatory statement as an introduction, it is proposed to survey briefly our findings in the industrial x-ray section of this installation, placing special emphasis on tuberculosis and the manner of handling the working man who unfortunately has a tuberculous involvement. An attempt will be made to cover the various methods of chest x-ray in use today and the method used here with the various advantages of this method. The system of classification of the patient used here and statistics of our results will be presented.

In a survey made at the University of Chicago, an attempt was made to correlate the various physical factors which influence roentgenographic and roentgenoscopic quality. They determined that:

"The resolving power of 14 x 17 inch roentgenograms is superior to that of all other roentgenographic materials. In order of merit below, these films may be listed, 4 x 5 inch photofluorograms, when made with a stationary-focused grid; 14 x 17 inch sensitized paper; 35 mm. photofluorograms when made with a stationary-focused grid, and 4 x 5 inch photofluorograms, made without a grid; 35 mm. photofluorograms, made without a grid; and finally, roentgenoscopy."

"The low resolution provided by the roentgenoscopic method may be attributed to the low visual acuity of the eye when operating at the low intensity levels present under roentgenoscopic conditions. A grid improves the diagnostic quality of photofluorograms by reducing the amount of scattered radiation reaching the fluorescent screen, and thereby increasing the contrast of the roentgen images. Due to the high inherent contrast of 14 x 17 inch paper film, a grid is not useful when these materials are employed." [2]

It was also found that a competent observer can detect infiltrating lesions between .5 cm. and 1 cm. by roentgenoscopy but that these lesions could more easily and reliably be detected by one of the plate methods.

A precaution urged by all workers in the field of chest survey is well worth mentioning at this point: The interpreter should clearly understand the diagnostic criteria of the roentgenographic process which he is using, or a large number of diagnostic errors will result. By comparing the previously accepted standard 14 x 17 inch stereoscopic film with one of the newer methods on the same patients, one is soon able to determine the above mentioned criteria and will improve with experience.[2] The diagnostic usefulness of the various methods of chest roentgenograms, according to various experienced interpreters, is in the following order:

1. 14 x 17 inch film, stereoscopic.
2. 14 x 17 inch film, single.
3. 4 x 5 inch film, photo roentgenographic stereoscopic.
4. 14 x 17 inch paper.
5. 4 x 5 inch film, photo roentgenographic, single.
6. 35 mm. film, photo roentgenographic, stereoscopic.
7. 35 mm. film, photo roentgenographic, single.[3]

The photo roentgenographic method of mass chest survey using 4 x 10 inch film, viewed through a special viewer, called an orthostereoscope, is the method of choice in the estimation of most roentgenologists engaged in this

1. Kirklin, B. R.: A Plea for Wider Employment of the Roentgen Rays in Examination of the Lungs. Collected Papers of the Mayo Clinic, 952-956, 1940; Saunders, Philadelphia.
2. Editorial R. H. M.: An Evaluation of the Roentgen Methods Used in Mass Chest Surveys. A. J. Roentgenology & Radium Therapy, Vol. 51, 759-761, June 1944.
3. Lindberg, D. O. N.: Pulmonary Tuberculosis. 1943, Thomas, Springfield.

type of work. The reasons for this choice are.

1. Economy—The basic cost is one-twentieth that of the 14 x 17 inch stereoscopic film.

2. Rapid chest exposure — As many as ninety patients per hour have been examined, using a rotating anode tube with an attached blower, whereas twenty patients an hour is perhaps the maximum number capable of being examined by the conventional old style method.

3. Rapid viewing — By concentrating the field of vision of the sharply defined image, one is able to quickly scan the field for various pathological defects.[13]

4. Ease of identification—A small typewritten slip of paper, using large bulletin type and a piece of especially heavy carbon paper, provides information as to the patient's name, date, etc., which is photographed on the plate at the time of examination.

5. Ease of storage and mailing—The film may be mailed in the standard 4½ x 10½ inch envelope and also stored in this size envelope in standard file drawers.

Each potential employee who is tentatively accepted for employment on this army field is given a physical examination including pre-employment chest x-ray. The apparatus consists of a 200 milliamp x-ray tube with an attached blower and a photo Roentgen unit with an attached Lysholm grid. A small percentage of patients prove to be too large to be examined on the small plates and it was found necessary to place the 14 x 17 inch film in a transverse fashion to obtain a complete survey of the chest. The technique used is as follows:

CONSTANT FACTORS:

| | |
|---|---|
| KVP | 100 |
| MA | 150 |
| Distance | 36 inches |

VARIABLE FACTOR—TIME

| | |
|---|---|
| —24 cm. | 2 tenths of a second |
| 25-27 cm. | 3 tenths of a second |
| 28-32 cm. | 4 tenths of a second |
| 33 cm. and over | Use 14 x 17 inch film |

PROCESSING PROCEDURE

| Exhaustion Period | Time of Development | Number of Film (4"x10") Developed in Tanks of Varying Capacity | | | |
|---|---|---|---|---|---|
| | 68° F | 6 gals. | 10 gals. | 15 gals. | 20 gals. |
| A | 8 mins. | 637 | 1125 | 1767 | 2468 |
| B | 9 mins. | 292 | 518 | 809 | 1130 |
| C | 10 mins. | 214 | 375 | 589 | 821 |

| DEGREES F. | EXHAUSTION PERIOD | | |
|---|---|---|---|
| | A | B | C |
| 64° | 9½ mins. | 10½ mins. | 12 mins. |
| 66° | 8½ mins. | 9½ mins. | 11 mins. |
| 68° | 8 mins. | 9 mins. | 10 mins. |
| 70° | 7½ mins. | 8½ mins. | 9 mins. |
| 72° | 6½ mins. | 7½ mins. | 8 mins. |

The Morgan Photo-timer greatly simplifies this technique by eliminating the necessity of measuring each patient. The controls are daily set for the KV and MA and this device terminates the exposure when the film has received the proper quantity of radiation, thus insuring uniform quality of the film. This uniformity of the film aids both in diagnosing and in preventing eye fatigue while reading the plates.[4]

A public health survey made with 35 mm. film had been conducted prior to the installation of the equipment and all cases which had been recommended, on the basis of the survey, to be reëxamined were called in for check-up plates. All cases showing suspicious lesions in the 4 x 10 inch film, plus the repeat cases from the public health survey were examined on 14 x 17 inch film. It was found that three classes would be required for proper designation of the film reports.

Class A consists of all employable cases not requiring x-ray recheck and includes such cases as: arrested minimal tuberculosis, such as primary calcified nodules; thoracic deformity; rib deformity; cervical ribs; spinal column deformity; diaphragmatic eventration; foreign bodies; dextracardia; enlarged heart; aneurysm; azygos lobe; emphysema; and calcified pleura.

Class B consists of employable cases pending x-ray and/or clinical recheck, such as: apical capping with underlying parenchymal lesion; exudative tuberculous lesions—minimal; fibrotic tuberculous lesions; moderate to minimal fibro-productive tuberculous lesions; some pneumothoraces, if under observation by

4. Hilleboe, H. E., and Gould, D. M.: Conquest of Tuberculosis in Industry. J. A. M. A., Vol. 125, 241-243, May 1944.
13. Zanca, P., and Herpel, F. K.: A Statistical Analysis of 100,000 Examinations of the Chest by the P. R. Method. Radiology, Vol. 43, 122-129, August 1944.

the family doctor; incompletely resolved virus pneumonias, hilar adenopathy; tumor masses; effusion; generalized fibrosis; bronchitis; pleurisy; thoracoplasty; and pneumoconiosis.

Class C consists of cases who are not employable by virtue of the following: cavitation or other evidence of active tuberculosis; tuberculous effusion; pneumothoraces not in Class B; oleo thoraces; and cases formerly in Class B and shown to have unstable lesions by repeated examinations and/or clinical findings.

The diagnostic features of tuberculosis are becoming of increased importance and should be recognized by every physician. Active tuberculosis may be diagnosed by six methods, and according to Lindberg, these vary in importance according to the type as follows:

*Primary Type:* History of contact; tuberculin test; x-ray; sputum; symptoms and physical signs.

*Early Reinfection Type:* Tuberculin test; x-ray; sputum; physical signs; symptoms; and history of contact.

*Late Reinfection Type:* Symptoms; physical signs; sputum; x-ray; tuberculin test; and history of contact.

In the primary or childhood healed type of tuberculosis, the x-ray findings consist of hilar calcified nodules with no parenchymal lesions and no marked mediastinal enlargement or Ghon Foci consisting of discrete scattered parenchymal calcifications, especially found in the lower portion of the lung lobes or in the hilar region. Miliary healed parenchymal calcifications of millet-seed size are occasionally seen and result from rupture into the blood stream of a pulmonary tuberculous focus with resultant healing and calcification.

The re-infection or adult type is recognized by the seven pathological entities of tuberculosis consisting of: infiltration; exudation; caseation; cavitation; fibrosis; combinations of the above and effusion.

A first infection may occur above the clavicle, but this is rare and most of the supraclavicular apical lesions are residual and consist of the so-called apical capping. Lesions of this type very seldom become active, however, fresh lesions may develop elsewhere in the lung. A brief review of the Roentgen appearance of the various pathological entities of tuberculosis might be in order.

The exudative lesion is a wooly, ill-defined homogeneous area of increased density, frequently found in the subclavicular areas at the periphery. The course of these lesions is to become either completely obscured or to coalesce and later develop caseation and cavitation.[5] Caseous tuberculosis is merely an extreme example of the exudative type and is characterized by an acute pneumonic consolidation (usually involving an entire lobe) similar in appearance to lobar pneumonia. The right upper lobe is the most frequent lobe involved in this type. Tuberculous cavitation is the result of caseation necrosis and is distinguished from other annular shadows by the surrounding wall of reaction, predilection for the upper lobes, and other signs of tuberculosis. Every case of suspected cavity should, if possible, be examined by means of a Laminagraph.

Chronic bronchial fibrotic involvement of the lungs is sometimes difficult to distinguish from the so-called fibroid phthisis. Fibroid phthisis is that form of chronic pulmonary



FIGURE 1

Tuberculosis with cavity formation found on a routine preëmployment chest x-ray in this survey. Patient was essentially negative regarding clinical history and symptoms. Placed in Class C as being not employable.

5. Shanks, Kerley and Twining: X-ray Diagnosis. Vol. I, 1938, Lewis, London.

tuberculosis which develops in cases in which the healing process is sufficient to prevent gross caseation but cannot completely stop progress of the infection. This results in a transformation of the lung area involved into a mass of fibrous tissue, which in turn, causes dilatation of the bronchi, retraction of adjacent structures and pleural thickening.[6]

Idiopathic pleurisy with effusion should be regarded as tuberculous until proven otherwise, except in patients over thirty years of age when malignancy must be considered.

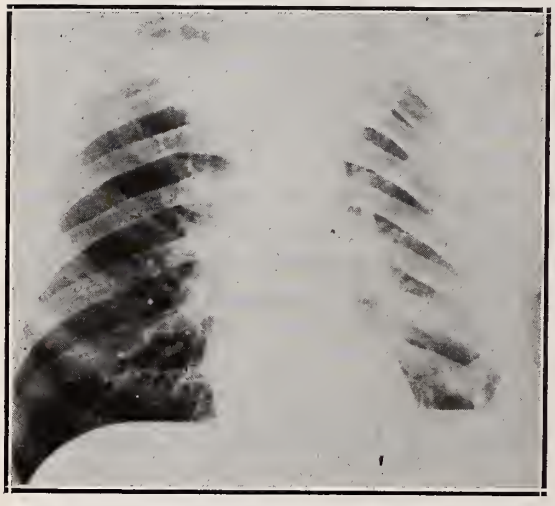


FIGURE 2

Tuberculosis with effusion found on a routine preëmployment examination with no clinical history obtained and patient admitted to symptoms only when told he was not employable.

Atelectasis is a frequent finding in pulmonary tuberculosis as the result of bronchial obstruction, secondary to a blood clot or changes in the bronchial wall.

A brief resume of the differential diagnosis of pulmonary tuberculosis would be well considered at this point.

Leukemic lymphadenosis consists of lymphocitic infiltration of the peribronchial and interlobar connective tissues which will closely simulate tuberculosis and may be, of course, differentiated by blood studies.

6. Emerson, C. P., and Taylor, J. E.: Essentials of Medicine, 717-741, 1940; Lippincott, Philadelphia.

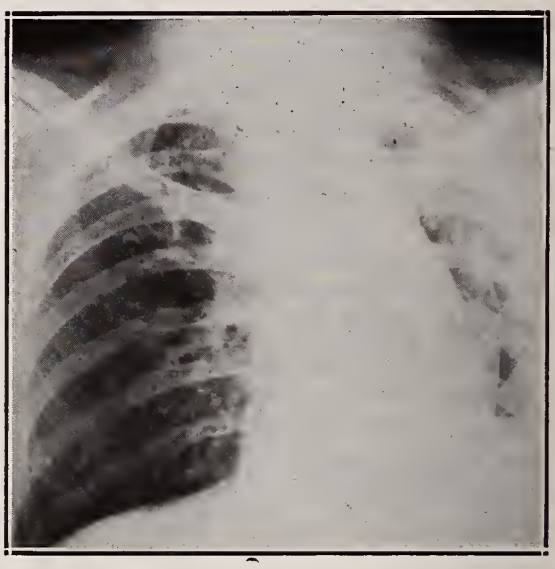


FIGURE 3

Tuberculosis with atelectasis and effusion. This patient, when informed of the findings, admitted to a long-standing tuberculosis history which had been disregarded by his family physician. Tubercle bacilli were found in the sputum.

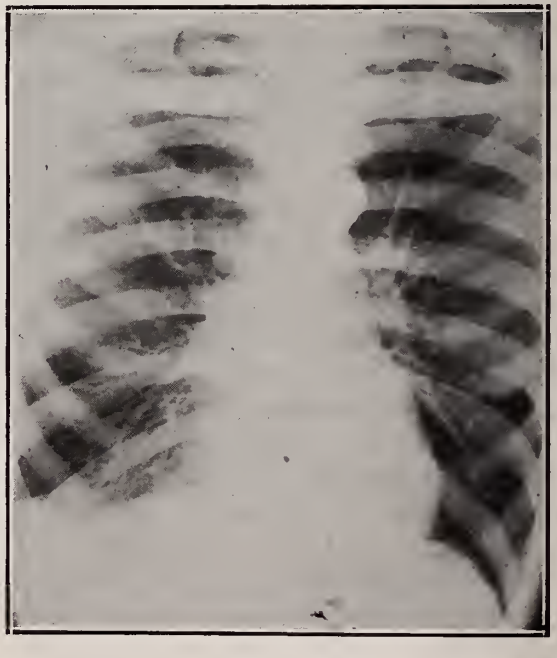


FIGURE 4

Asthma with partial collapse of right lower lobe. Subsequent x-rays showed complete re-expansion with persistence of the asthmatic physical findings and symptoms.

Calcicosis simulates a massive hematogenous pulmonary tuberculous spread. It will frequently completely clear a short time after the patient is removed from contact with chalk dust.[7]

Dr. Rest presents a case of thoracic adeno carcinoma consisting of an area of increased density in the subclavicular portion of the lung which had the appearance of tuberculosis. Pulmonary metastasis may give the appearance of tuberculous infiltration, exudation, and even of cavity formation. By searching for the original malignant lesion and the lack of tubercle bacilli in the sputum, this condition may be differentiated.

Sarcoidosis can cause an appearance of tuberculous fibrotic strands and nodules of the lungs. However, the skin and bone manifestations are usually present, thus enabling one to make a correct diagnosis.

Pulmonary nodules and tubercles, as classified by Cole in his discussion of pneumoconiosis, may cause difficulty in the differential diagnosis of tuberculosis. He lists these nodules as follows:

A. Dust nodule: Consisting of small irregular spherical masses in relationship to the peripheral blood vessels and bronchi.

B. Silicotic nodules: Consisting of whorls of collagen widely disseminated through the lungs bilaterally, relatively symmetrical and with no constant relationship to the blood vessels and bronchi.

C. Dust tubercles: Look the same as tuberculosis tubercles on the x-ray plate and even under the microscope, but when further studied, are noted to contain only collagen and dust laden phagocytes.

One of the best graphic presentations of pneumoconiosis is illustrated in Figure 5.[9]

The differentiation from tuberculosis of silicosis is aided by the history, clinical findings and repeated x-ray examination. A case of granular silicosis is illustrated in Figure 6.

Effusion of the chest should always be viewed with suspicion. Unresolved effusion, secondary to pneumococcic pneumonia, the effusion of cardiac failure, effusion of malignancy, Hodgkin's disease, etc., must be considered in the differential diagnosis of tuberculous effusion.

Pulmonary fungus infections simulate tuberculosis but no tubercular organisms are present and frequently the offending fungus may be identified. The clinical course and check-up x-ray, plus the laboratory studies, should provide the diagnosis.

Bronchopneumonia usually clears in several weeks, though until that time it may closely resemble tuberculosis. The clinical course, repeated x-ray examination, physical examination and laboratory studies, will furnish the diagnosis.

Lobar pneumonia presents the same x-ray appearance as tuberculous caseation; however, the latter persists beyond the usual course of pneumonia and cavities later appear. A difficult diagnostic feature of this condition is that in tuberculous caseation, tubercle bacilli cannot usually be demonstrated initially in the sputum.

Bronchiectasis is sometimes a confusing condition, but may be diagnosed by means of a bronchogram. Pulmonary syphilis will usually rapidly react to antiluetic therapy.

Regarding the incidence of tuberculosis, Amberson makes the following statements:[10]

"The factors of age and sex are of great importance, particularly in relation to occupation. As stated, tuberculosis remains the most disabling and fatal disease in the most productive years of life. More specifically, in the experience of the Metropolitan Life Insurance Company with its industrial policy holders in the period 1926 to 1930, tuberculosis was the leading cause of death in the age range twenty-five to forty-four years for white males; fifteen to thirty-four for white females; fifteen to forty-four among colored males; and five to thirty-four among colored females. According to the statistical studies of Jessamine S. Whitney, tuberculosis stood second in 1930

7. Rest, A.: The Roentgenogram and Some Chronic Non-Tuberculous Pulmonary Conditions. A. J. Roentgenology and Radium Therapy, Vol. 51, 434-438, April 1944.
8. Cole, L. G.: Pneumoconiosis. A. J. Roentgenology and Radium Therapy, Vol. 51, 125-177, February 1944.
9. U. S. Public Health Service, Bulletin 244, 1939.
10. Amberson, J. B.: Tuberculosis and Other Pulmonary Diseases. Industrial Hygiene, Lanza and Goldberg, 68-110, 1939; Oxford University Press, N. Y. C.

## SCHEME REPRESENTING THE SEQUENCE OF LUNG-FIELD MARKINGS IN A TYPICAL CASE OF UNCOMPLICATED SILICOSIS

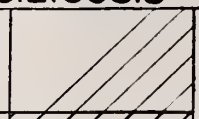
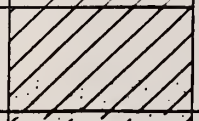
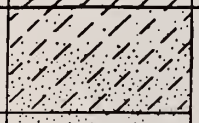
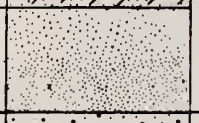
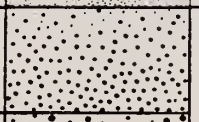
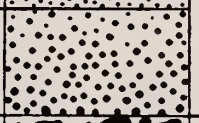
| | | | |
|---|---|---|---|
| LINEAR | NORMAL LUNG MARKINGS & 1ST DEGREE EXAGGERATION OF LINEAR PULMONIC MARKINGS. |  | This is the range of markings usually seen on X-ray examination of persons who have never worked in a dusty trade. |
| | 2ND DEGREE EXAGGERATION OF LINEAR PULMONIC MARKINGS, WITH OR WITHOUT BEADING. |  | |
| GRANULAR | 1ST DEGREE DIFFUSE GROUND GLASS OR GRAINY APPEARANCE, NOT OBLITERATING LINEAR MARKINGS. |  | These are the earliest markings in the sequence of dust-induced changes which can be clearly differentiated from the changes that usually accompany advancing age, bronchitis, cardiac stasis, etc. |
| | 2ND DEGREE DIFFUSE GROUND GLASS OR GRAINY APPEARANCE, OBLITERATING LINEAR MARKINGS. |  | |
| NODULAR | 1ST DEGREE DISSEMINATED NODULES UP TO SIZE OF MILIARY TUBERCLES. |  | Cases with granular or nodular markings may be diagnosed as stage I or stage II silicosis depending on signs and symptoms present |
| | 2ND DEGREE DISSEMINATED NODULES EXCEEDING 1M M IN SIZE. EMPHYSEMA PRESENT, USUALLY. |  | |
| COALESCENT NODULES AND CONGLOMERATE SHADOWS (EMPHYSEMA ALWAYS PRESENT) | |  | May be diagnosed stage II or stage III depending on signs and symptoms present and degree of disability. |

FIGURE 5
The above scheme is a graphic presentation of silicosis on the basis of x-ray findings (U. S. Public Health Service Bulletin 244, 1939).

as a cause of death among gainfully employed males from fifteen to sixty-four years of age in the United States. Of all the deaths among women between the ages of fifteen and twenty-five, about one-third are caused by tuberculosis. * * * it is seen that among women the mortality declines sharply after the age of thirty, whereas among men it continues to rise so that around the age of sixty, the male death rate is approximately three times that among females."

X-ray examination showed 0.9 per cent of the selectees examined in the Boston Armed Forces Induction Station to have pulmonary tuberculosis with 1.4 per cent average from the poorest communities and a .7 per cent from the best. It was found that density of population was more of an influencing factor than the economic status, since the incidence showed

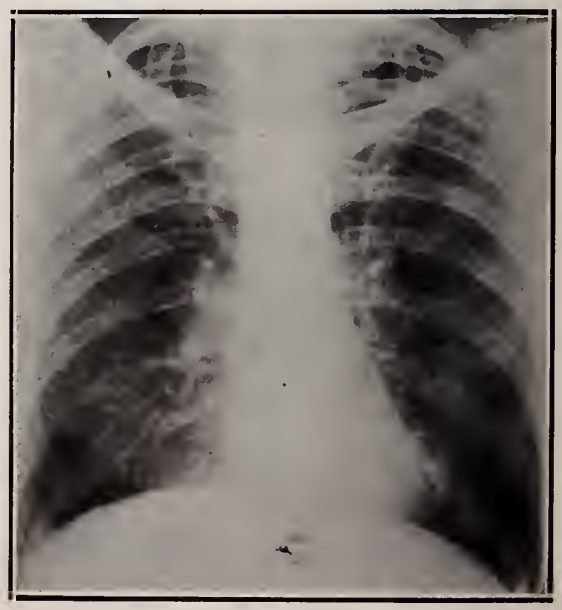


FIGURE 6
The above is a case of granular pneumoconiosis with a history of 15 years' previous employment in a glass factory.

a sharp increase from the 5,000 population per square mile to the higher densities.[11]

Tuberculosis is present in the body at birth only in those rare cases when the mother has miliary tuberculosis. Almost every case is acquired after birth, during infancy, when the lymph channels are open to the tubercle bacilli. The percentage of primary infection in the United States under twenty-one years is now less than 20 per cent and of these, many develop secondary tuberculous infection, but only about 2 per cent of these persons have symptoms and only 10 per cent of those die of tuberculosis. The yearly death rate from tuberculosis has dropped from 200 per 100,000, thirty years ago, to 60. The most logical reasons for this decrease and for future reduction are the vigorous sanitary measures, such as apply to spitting and protection of milk supply, plus the use of the chest x-ray. Fifty per cent of persons with well developed pulmonary tuberculosis, if adequately treated, are able to return to an active life as arrested cases.[6]

The incidence of active tuberculous reinfection found in our preëmployment survey was 0.32 per cent. Since Class B cases included conditions other than tuberculosis, our check-up examinations were relatively high. Many of the Class B cases have been rechecked several times, some for tuberculosis and others for virus pneumonias and similar conditions.

Approximately 20,000 chest examinations have been made in little less than a year at this installation, about half of which were done by a Public Health Survey. Of the preëmployment examinations made with our permanent equipment, 95.61 per cent were immediately placed in Class A as being acceptable and not requiring check-up examinations. Four and fifteen one-hundredths per cent were placed in Class B for one of the reasons listed previously in this paper and .24 per cent were placed in Class C as the result of obviously active tuberculosis.

Rechecks on the Public Health Survey, rechecks from the Class B cases, and examinations of employed personnel who were not surveyed and had not had a preëmployment x-ray, totaled about 1,500.

From this group, 0.96 per cent were placed in Class C. This figure is somewhat confusing since it was the result of culling down many suspiciously active tuberculosis cases to a smaller group and in order to more accurately interpret the significance of this figure, it becomes necessary to examine the Public Health Survey study which had been made prior to the installation of our photo roentgenographic unit.

This survey was made on a voluntary basis on the employed personnel, of whom 76.4 per cent of the total employed were examined. Incidentally, this was an excellent percentage as compared to other similar studies, since 50 per cent of the total employed is regarded as being satisfactory. The results of this survey may be summarized as follows:

1. Number of employees x-rayed ..... 10,697
2. Number of employees to be re-rayed. 200
3. Number of employees available for re-ray at the time of installation of our photo roentgenographic unit ..... 125

Of the 125, forty-two were found to be Class A, eighty-one in Class B and two in Class C. It is readily seen that 75 cases found in need of further checking had left the field between the time of the survey and the time we were ready to examine them so that the total incidence of tuberculosis and the incidence of active tuberculosis would most likely have been higher than listed below, if these people had been available.

SUMMARY OF RESULTS OF THE TWO SURVEYS

| | |
|---|---|
| PRE-EMPLOYMENT: | |
| Class A | 95.61% |
| Class B | 4.15% |
| Class C | .24% |
| HEALTH SURVEY RECHECKS AND ROUTINE EXAMS: | |
| Class A | 89.91% |
| Class B | 9.13% |
| Class C | .96% |
| TOTAL INCIDENCE OF TUBERCULOSIS | 2.46% |
| AVERAGE INCIDENCE OF ACTIVE TUBERCULOSIS | .60% |

A similar survey conducted by the Public Health Service on 559,306 people in industrial groups showed 1 per cent to have positive

11. Hyde, Zacks, and Kingsley: A Community Study of Pulmonary Tuberculosis in Selectees, New England Journal of Medicine, Vol. 229, 811-817, November 1943.

tuberculosis findings. Of these, 62 per cent were minimal, 31 per cent moderately advanced and 7 per cent far advanced.[4]

It is of interest that the incidence of obviously active tuberculosis in our preëmployment examinations was only 0.24 per cent since the people employed in this installation were drawn from 4-F's, Army rejectees, older people, and others not able to meet the physical requirements set up by other industrial centers. Many of those employed were, however, from rural sections who had previously worked on farms and this may account for the relatively low incidence of tuberculosis. Many individuals employed at this station have physical inadequacies. Some 1,527 handicapped workers are being utilized in selected jobs and under a medically supervised program are paying dividends to all concerned.

Those cases noted to have tuberculosis which was not obviously active, were given notification of their condition and advised to report to their family physician. Proof of consultation was required in the form of a note from the Doctor stating that in his opinion the patient was not actively infected and in addition, check-up x-rays and physical examinations were performed on these cases as often as indicated. When a case was found to be obviously active, the local Board of Health was notified and it is worthwhile to note that each of these cases is now receiving, or has received sanatorium treatment.

The above method of coöperation with the Local Board of Health and the family physician has proven very satisfactory.

Tuberculosis is a preventable disease and, therefore, a control program should exist in every community. Case finding activities should provide for the routine examination of all contacts. We report all of our active cases to the Local Board of Health and all check-up work and case finding is left to it. We feel that by examining all people employed in this installation, we are making a definite contribution towards surveying a portion of the local population and are at least eliminating active cases of tuberculosis from contact with fellow workmen. It is felt that all cases of re-infection type of tuberculosis should be x-rayed at least once a year and that tuberculous contacts should be examined at least semi-annually.[3]

Lindberg cites a case of a contact youth who was examined by x-ray in February and found to have no parenchymal lesions. In August he had a pulmonary hemorrhage which he ignored. In November of the same year, an x-ray showed bilateral advanced tuberculous involvement, from which he later died.

The time of development of tuberculosis, following contact, varies and may be much sooner than formerly expected. It would perhaps be wise to adopt some type of industrial survey system that would permit yearly examination and, in the Armed Forces, a reëxamination six months following induction. Cases have been recorded that definitely show that patients can develop significant x-ray tuberculous lesions within 60 days of contact.[12]

At this time there are 190 people with old tuberculous lesions working at this installation. The employing of these individuals is part of a modern health program carried on by the medical section of this field. The exigencies of war made it necessary to employ handicapped people who were formerly dependent on their families or the relief organization, since they were not regarded as being physically adapted to work in industry and could not find full-time employment. Tuberculosis was one taint of many which caused rejections from industrial occupation. Cases with orthopedic defects, impaired vision, and hearing, cardiac disorder, etc., are assigned here where they will be free from any feature which would aggravate their condition. His or her physical status is periodically checked and all transfers are supervised by the medical section. Under such a program, there is no reason why a person with tuberculous lesions which remain quiescent cannot be gainfully employed.

## CONCLUSIONS

1. The methods of various mass chest x-ray examinations have been presented and the photo roentgenographic 4 x 10 inch stereo film is concluded to be the best of its type for reasons stated.

12. Rigler, L. G.: Significance of the Negative Roentgenogram in the Search for Pulmonary Tuberculosis, Radiology, Vol. 43, 68-69, July 1944.

2. The technique of the photo roentgenographic method has been given.

3. A classification system for reporting preemployment chest x-rays used at this station has been described and examples illustrated.

4. A brief resumé of the diagnostic features of tuberculosis, and the differential diagnosis has been given.

5. The incidence of active tuberculosis in the preëmployment chest x-ray was found to be 0.24 per cent.

6. About 190 people with pulmonary tuberculosis lesions are at present employed at this installation and are receiving periodic checks by the medical section and their family physician.

7. Pulmonary tuberculosis is a disease that requires the maximum of intelligent guidance by the industrial physician plus full coöperation of all concerned. If this is universally obtained, there is no reason why tuberculosis cannot be completely eliminated from its present status.

## WITH NEW JERSEY MEDICAL AUTHORS

Compiled by MILDRED V. NAYLOR, Librarian, Academy of Medicine

It is requested that any New Jersey physician who publishes an article outside the state, notify the Editorial Office in Trenton, giving the title of the paper and the name of the periodical, as well as the month, date, volume and page number. It would also be helpful to this office if members would notify us of articles published by their colleagues.

BERKOW, SAMUEL G.—Perth Amboy (in service)
Tape method of skin-grafting. U. S. Nav. M. Bull. 45: 1-13, July 1945

KLER, JOSEPH H.—New Brunswick
An analysis of colds in industry. Arch. Otolaryng. 41: 395-407, June 1945

LEVINE, PHILIP—Linden
Recent developments in iso-immunization by the Rh factor. Am. J. Obs. & Gyn. 49: 810-814, June 1945

NAYLOR, MILDRED V.—Newark
The Exchange and the policies underlying its administration. Bull. M. Lib. A. 33: 357-359, July 1945

POMERANZ, RALPH—Newark (in service)
Neurofibroma of the cauda equina: Report of a case. Radiology 44: 588-592, June 1945

STOCKFISH, ROBERT A.—Jersey City (with Daniel Kravitz)
Wernicke's disease (encephalitis hemorrhagica superioris). Am. J. Ophth. 28: 596-600, June 1945

WATERS, EDWARD G.—Jersey City
Supravesical extraperitoneal Cesarean section (Water's type). Am. J. Obst. & Gynec. 49: 739-746, June 1945

## STATE BOARD OPPORTUNITY

The following resolution was passed at a meeting of the State Board of Medical Examiners held on July 11th:

"That candidates for licensure in the State who are now serving an internship beginning July 1st, will be permitted to take the October examination."

E. S. HALLINGER, M.D., Secretary.

# MANAGEMENT OF THE RECURRENT VESICULOPUSTULAR ERUPTIONS OF THE HANDS AND FEET*

LIEUT. COMDR. C. C. CARPENTER, (M.C.) U.S.N.R., Summit, N. J.

During the past fifteen years there has been an increased understanding of the diverse causes which produce these annoying and disabling types of skin eruptions.

Prior to 1921 such outbreaks were considered to be solely of nervous or idiopathic origin, but with the description of Williams of their toxic fungus origin,[1] and the supportive studies of Peck, who experimentally reproduced these lesions,[2] the pendulum swung to the extreme, where all such eruptions were considered of a fungus nature. During the past ten years, this single concept of etiology has been proved to be erroneous by many separate investigators, and today the recognized causes are so diverse that some plan of management should be formulated to insure adequate investigation, suitable therapy, and recommendations to prevent future recurrences.

To facilitate the management of these recurrent eruptions, they may be conveniently divided according to etiology into—

1. *Ingestion Group*—Lesions that are produced or aggravated by the ingestion of foods or drugs.

2. *Contact Group*—As reactions to local applications of antiseptics, irritants, medications, or by various occupational causes.

3. *Fungus Group*—A direct infection of the feet or hands, or both, by fungi or yeast, or an allergic manifestation of the skin of the feet, hands, or both to a primary fungus or yeast focus, elsewhere on the skin, in the gastrointestinal tract, or in the vagina. Such eruptions are referred to as "ids".

4. *Bacterial Group*—Direct infections of the hands and feet, or both, with staphylococci and streptococci, or an allergic form in which the "ids" are produced by either a direct infection of the skin at some remote area, or by internal foci of infections.

5. *Miscellaneous Group* — These include those due to gastrointestinal intoxication, changes in temperature and climate, nervousness, or idiopathic causes.

## CLINICAL DESCRIPTION

Although many authors stress some minor clinical differences between the various types of these eruptions, there are no definite distinctive characteristics which will give a clue to their etiology.[3,4,5] The eruption usually begins with superficial or deep vesicles which are pinpoint to pin-head size, on the sides of the fingers and/or toes, or on the palms and/or the plantar surfaces, or the backs of the hands and/or dorsa of the feet. They rarely extend beyond the ankles or wrists. As the process becomes more intense, vesicles may coalesce to form bullae, and pustules to produce a honey-combed appearance. As the eruption recedes, it leaves a superficial desquamation, in the form of little collarettes if it has been mild in type, or complete exfoliation of the skin where the process has been intense. Eczematization frequently occurs with weeping and crust formation, and there may be an incapacitating edema of the skin in these areas, which interferes with the normal movements of the feet and hands and gives rise to burning and itching.

The eruption is usually symmetrical and only a few fingers, or toes may be involved on each hand or foot.[6,7] Due to a frequent invasion of the nail bed, these structures may show pitting, ridging, or other forms of dystrophia, and the nail may even be shed.[6] It is the con-

* Read in part at the May 25, 1944, meeting of the Staff of the U. S. Naval Hospital, Brooklyn, New York. Captain Gardiner E. Robertson, Medical Officer in Command.

1. Williams, C. M.: Dermatophytid (Complicating dermatophytosis of the glabrous skin). Arch. Dermat. & Syph., 13:661. 1926.
2. Peck, S. M.: Epidermophytosis of the Feet and Epidermophytids of the Hands. Arch. Dermat. & Syph., 22:40. July 1930.
3. Wise, F., and Wolf, J.: Dermatophytosis and Dermatophytids. Arch. Dermat. & Syph., 34:1. July 1936.
4. Becker, W. S.: Vesicular and Vesiculopustular Eruptions of the Hands and Feet. J. Michigan M. Soc. February 1942.
5. Ayers, S., and Anderson, N. P.: So-called Fungus Infections of the Hands. California & West. Med., 56:2. February 1942.
6. Ormsby, O. S.: Diseases of the Skin. Lea & Febiger, Phila. 1937.
7. Hopkins, H. H., et al.: Cutaneous Autosensitization (Role of the Staphylococci in Chronic Eczema of the Hands). Arch. Dermat. & Syph., 49:124. 1944.

sensus at the present time that such eruptions do not involve the sweat or sebaceous glands,[3, 8, 9] and that therefore dishydrosis is a misnomer, and a better terminology is "recalcitrant vesicular eruptions of the hands and feet" as suggested by Andrews.[10]

### INGESTION GROUP

It is not uncommon to see these eruptions aggravated if not actually produced by foods and drugs in allergic individuals. For this same reason heredity is believed to be a definite factor and familial cases are seen.[8, 11] The blood count as well as the history is useful in determining the existence of these forms of allergy, where foods are involved the white blood count is normal or a little low with an increase in the eosinophils, whereas a definite leucopenia and a relative lymphocytosis points to a drug idiosyncrasy.

Although any food may be suspected, it seems that the citrous fruits are the ones most frequently the culprits. Among the drugs that have been incriminated are the salicylates,[12] ephedrine,[13] mecholyl,[4] sulfonamides,[14] and penicillin.[15] A period of hospitalization is useful in these cases so all medications may be controlled and "test negative" or "elimination diets" for food allergy rigidly enforced. During the period of study, no x-ray therapy or ointments should be used so that fresh efflorescences of vesicles will not be masked by the local treatment.

### CONTACT GROUP

All authorities agree that these recurrent vesicopustular eruptions may be aggravated or even produced by contact irritants. Their estimates vary from 10 per cent to 50 per cent of the cases seen. They are found more frequently in patients who work in occupations where irritants are frequently handled. This is particularly true of housewives, doctors, nurses and dentists, from the use of strong soap solutions, bleaches, and disinfectants. It is frequently the result of working in munition plants, rubber processing, leather work, photography, etc.[3] More specifically local applications of iodine,[12] arsphenamine,[16] dyes and acids[17] have been incriminated as causes.

Removal of these individuals from all possible contact by a period of hospitalization is indicated. Patch tests of all suspected agents[5] should be carried out, as well as, for all ointments and lotions that might possibly be used in the treatment of the patient. All personal toilet articles, cosmetics, flowers, fruit, etc., should be forbidden in the patient's room and as far as possible, contact should be limited to "air, cotton, and water".[18]

With soothing therapy composed of previously tested ointments, and lotions, as well as mild x-ray therapy, the vesiculation produced by exogenous irritants should clear within a two-week period. It is well to bear in mind, however, that external irritants are commonly the aggravants of an existing trichophytid, moniliid, or bacterid, and the possibility of these underlying conditions should be thoroughly excluded to prevent the possibility of future recurrences.

### FUNGUS GROUP

As a rule, fungus and yeast infections start in the intertriginous areas, as between the toes, in the groin, inframammary areas, and axillae, with an erythema, itching, scaling, and vesiculation. Microscopic preparations of the scales and roofs of vesicles prepared with 10 to 15 per cent KOH reveal the typical branching, doubly-refractile mycelia of the causative organisms and cultures of similar material derived from these involved portions grow characteristic cultures of fungi or yeast. The incidence of these infections is higher in summer[4]

8. McLachlon, A. D., and Brown, H. W.: Cheiropompholyx. Brit. J. Dermat., 46:457. November 1934.
9. Fox, Howard: Personal communications.
10. Andrews, G. C., et al.: Pustular Bacterides of the Hands and Feet. Arch. Dermat. & Syph., 32:837. December 1935.
11. Wise, F.: Discussion of Senear, F. E.—"Recurring Vesicular Eruptions of Palms and Soles." American Academy of Dermatology Meeting, New York City, 1941.
12. Muende, I.: Cheiropompholyx. Brit. J. Dermat., 46: 479. 1934.
13. Carpenter, C. C.: Pomphlyx Produced by Sensitivity to Ephedrine. Arch. Dermat. & Syph., 34:1028. December 1936.
14. Carpenter, C. C., and Gorsuch, P.: Aggravation of Bacterides by Sulfonamides. Nav. Med. Bull., Vol. 40. April 1945.
15. Graves, W. N.; Carpenter, C. C., and Unangst, R. W.: Recurrent Vesicular Eruptions Appearing During Administration of Penicillin. Arch. Dermat. & Syph. 50:6. July 1944.
16. Szarvas, A.: Uber die durch Arsenobenzol-Praporte hervorgerufenen asthmatichen anfalle und Dyshidrose. Deutsche Med. Wchnschr. 60:1751. 1934.
17. Von Kemeri, Dezso: Etiology of Dishydrosis—Dermat. Wchnschr. 91:1587. October 1930.
18. Sutton, R. L., Jr.: Personal communication.

or in hot humid climates. Following a latent period of three weeks in initial infections, or almost immediately in recurrent eruptions, many individuals with an allergy to the fungus toxins may develop deep sago-like vesicles of the palms and plantar surfaces of the feet. These dermatophytids (fungus) or moniliids (yeast), are caused by the transportation of living organisms or their toxins by the general circulation to these sites.[2] As there is always a rapid destruction of these fungi or yeasts before the formation of the "id", organisms are rarely found on the hands by microscopic or cultural examination.

It is well agreed by all observers that direct primary fungus injections of the hands are extremely rare, Becker [4] encountered only three proved cases in fourteen years at the University of Chicago, and Light [19] found only 2 per cent positives in approximately 600 patients at the New York Skin and Cancer Hospital.

It has been repeatedly demonstrated [1, 20, 21, 22] that, in individuals with a secondary allergic vesicular reaction on their hands or feet, the trichophytin test is positive and in addition may be the cause of an exacerbation of a previously quiescent "id" eruption.

The diagnosis of a primary fungus or yeast infection of the hands and/or the feet, or intertriginous spaces with a secondary eruption of the hands and/or feet then rests on the microscopic or cultural demonstration of the presence of a fungus or yeast in the suspected primary focus and a positive trichophytin or oidiomycin test which may produce a local aggravation of any existing "id" within 48 hours. If these criteria are present, there is no difficulty experienced in effecting an improvement by the use of fungicidal agents.[23] Only weak concentrations of fungicides should be used at first because the toxins liberated by the too rapid destruction of the yeast or fungus may cause the production of, or further aggravate any existing "ids". Its strength may be increased within two to three days so that the primary focus becomes microscopically negative within ten days. Soothing local therapy or superficial x-ray treatments are sufficient to control the "id" eruption of the hands, as these ultimately subside with improvement in the primary focus.

The use of Trichophytin extract alone has been a disappointment in desensitizing an individual to further "id" recurrences as Sulzberger and Wise [22] were able to obtain marked improvement or cures in only 7 out of 18 patients. In a further series of 200 cases the same authors with Lewis [24] were able to reduce the skin sensitivity to the trichophytin extract, and in some cases reduced the symptoms of the dermatophytids, but at no time was there any clearing of the primary focus.

To prevent the recurrences of primary fungus or yeast infections, as well as to control the resulting "id" formations, it has been our practice to recommend control of carbohydrate intake [25] so that the skin will not be as predisposed to these infections. The local use of a fungicide at least once or twice a week to the sites most frequently involved, whether or not any apparent abnormality is present, and to use desensitizing dosages of trichophytin, oidiomycin, or both if a high degree of sensitivity exists to these extracts.

Many times there is a super-imposed bacterial infection, at the sites of a primary fungus involvement, which must be treated as well,[26] since it frequently happens that the individual may become sensitized and develop bacterides from these secondary invaders. In such double infections, good results have been obtained by alternating a 5 per cent Sulfathiazole cream with an iodine, salicylic acid, alcohol preparation,[23, 26] or the use of sulfonamides internally.[28]

19. Light, S. E.: Microscopic Demonstration of Ringworm. Arch. Dermat. & Syph., 24:108. 1931.
20. Van Dyck, L. S., et al.: Use of Trichophytin as a Diagnostic and Therapeutic Agent in Mycotic Infections of the Skin. New York State J. Med. May 1931.
21. Williams, C. M., and Carpenter, C. C.: Trichophytin in Diagnosis. Arch. Dermat. & Syph., 25:847. May 1932.
22. Sulzberger, M. B., and Wise, F.: Ringworm and Trichophytin. J. A. M. A., 99:1759. 1932.
23. Carpenter, C. C.: Treatment of Ringworm of the Feet. J. M. Soc. New Jersey. 1935.
24. Sulzberger, M. B.; Lewis, G. M., and Wise, F.: Trichophytin and Allergy to Trichophytin. Arch. Dermat. & Syph., 34:207. 1936.
25. Carpenter, C. C.: Glucose Tolerance Test in Recurrent Infections Intertrigo. J. M. Soc. New Jersey. October 1939.
26. Gougerot, H.: Differential Diagnosis of Dishidrosis. Rev. gen. de clin. et de therap., 50:769. November 21, 1936.
27. Mitchell, J. H.: Amycotic Dermatosis Simulating Ringworm and Erosio Interdigitalis Blotstomyectica. Arch. Dermat. & Syph., 19:659. April 1929.
28. Montel, L. R.: Treatment of dishydrosis and dishydrotic eczema with sulfanilamide derivatives internally and externally. Rev. med. franc. d'Extreme-Orient., 16:44. 1938.

BACTERIAL GROUP

It is well recognized that bacteria or their products may cause vesiculopustular eruptions of the hands or feet morphologically similar to those produced by ingestion, contact, fungus, etc. These may be divided according to etiology into a primary group due to direct infection, and a secondary group which represents an allergic response to infection elsewhere in the body.

A. *Primary Group:* In this type the vesicles or pustules on the hands or feet contain viable streptococci or staphylococci,[4, 5, 27, 28] and the diagnosis depends on the finding of such living organisms in the vesicopustular fluid. Bacterial sensitivity tests to the same organisms recovered from the fluid need be strongly positive only in those cases found to have a concurrent secondary "id" reaction.

B. *Secondary Group:* In this type, referred to also as "id" (bacterid), the vesicles and pustules are sterile, and are due to an allergic sensitivity of the skin to circulating bacterial toxins or their products, from a primary infection of the type just referred to, or from some endogenous foci of infection.[3, 10, 29] These cases show leucocytosis and inceased sensitivity to bacterial vaccines by intradermal test. They are usually characterized by pustule formation, but distinctly vesicular phases are noted particularly in recent efflorescences.

The mechanism by which these lesions are produced is explained by Von Kemeri [17] as an inflammation of the terminal lymph spaces, and Hopkins [7] has recently advanced the opinion that the lesions may be due to the action of bacterial toxins on keratin to produce a local autosensitization of the skin to its own keratin. This is further supported by Hecht, Sulzberger, and Weil,[30] who have experimentally produced anti-skin anti-bodies in animals.

While as stated, diagnosis in the secondary or "id" group depends on the finding of strongly positive bacterial sensitization tests, leucocytosis, and the obtaining of sterile cultures from the vesicopustules, we have found a therapeutic test with Sulfathiazole or Sulfadiazine an invaluable aid in differential diagnosis. Small daily doses of the sulfonamide are given orally and the clinical response noted. In the greater percentage of cases, there is prompt definite improvement. This improvement rules out contact dermatitis, and also excludes fungus as an etiological agent since the sulfonamides have been shown to be of possible value in fungus infection only when used locally.[31, 32]

In a lesser percentage of cases the administration of the sulfonamides produces an aggravation of the existing bacterides, or the production of new "id"-like lesions, accompanied by an elevation in temperature, and further increase in the leucocyte count.[14] Since the lesions of the secondary group are due to bacterial allergy, usually of endogenous origin, we have interpreted this aggravation to a too rapid release of bacterial toxins, or other products, from the primary foci with a resultant disturbance of the usual immunological balance to these substances. Here again this aggravation is helpful in excluding contact, fungus, and other miscellaneous possible etiological agents provided that true sulfonamide hypersensitivity is excluded.

Because of the potentiality of these, at times severe aggravations, we cautiously administer gradually increasing doses beginning with one .5 gm. tablet for the first twenty-four hours, and increasing the daily dose by a tablet a day until, if there has been no adverse reaction, four or more tablets are ingested each day. If during the administration of the drug aggravation occurs, the dose may be decreased temporarily, and when the reaction has subsided, smaller increments in dosage may be made until a satisfactory dose level or clinical response is obtained.[14]

Treatment of the primary group of bacterial infections of the hands or feet may be satisfactorily carried out by the local use of antiseptics such as solutions of Bichloride of Mercury, or Potassium Permanganate as wet dressings, beginning with weak dilutions and progressing to stronger ones, or by the local application of merthiolate, metaphen, or dilute

29. Alfoldy, E.: Nasal and Pharyngeal Diseases as Causes of Dishydrosis and Eczema. Acta-oto-laryng., 22:76. 1935.
30. Hecht, R.; Sulzberger, M. B., and Weil, H.: Studies in Sensitization to Skin. J. Exper. Med., 78:59. July 1, 1943.
31. Rademacher, C. J.: Treatment of Trichophytin Foot Infections in the Field. Mil. Surgeon. 90:431. 1942.
32. Lewis, G. M., and Hopper, M. E.: Effect of Sulfonamide and Its Derivatives on Fungi. Arch. Dermat. & Syph., 44:1101. December 1941.

iodine. Sulfonamides may also be used internally or externally with good effect.[28] Once the primary focus is healed, accompanying "ids" will quickly subside with soothing therapy, and a few fractional x-ray treatments.

It is with the treatment of the secondary group that we have been particularly interested, since these cases are usually the most recalcitrant to treatment. After the diagnosis of this type is definitely established, a thorough search of all possible foci is carried out clinically and by cultural methods, concommitantly skin tests are performed using various bacterial vaccines, and should the patient be hyperreactive by test to the type of organism recovered from such suspected focus, as compared with tests to unrelated bacterial, there is far greater indication for removing that focus, because it has been shown that the degree of intradermal reaction to bacterial and fungus vaccine is not dependent on the nitrogen content of the vaccine, but on some other factor[33] —probably a true sensitivity. The removal of the causative focus (teeth or tonsils), and the treatment of those that cannot be removed (prostate, cervix, or sinuses) is recommended by all observers,[3, 7, 10, 17, 29] and is followed by recovery in a large percentage of cases.

For those cases in which removal of the focus is impractical, or where recurrent vesicopustules continue to appear after the focus of infection is removed, or finally in those where no focus is found and a definite skin test hypersensitivity exists, desensitization by bacterial vaccines should be employed.

This method has been used by Graham and Traub,[34] using autogenous streptococcus vaccines, and although no permanent cures were obtained, they felt that this form of therapy had distinct possibilities. More recently, Hopkins[7] obtained good results with desensitization to an especially prepared staphylococcus toxin administered over a period of one year.

As our interest grew in this problem, and with the intradermal testing of many individuals suffering from recurrent vesicopustular eruptions, we were impressed by the large number of cases that gave a history of antecedent "athlete's foot" or fungus infection, and who in addition to bacterial hypersensitivity displayed strongly positive fungus and yeast vaccine reactions. We soon became convinced that this might be of significance in the etiology and recurrence of this syndrome. Although no mention could be found in the literature of an immunological relationship between bacteria and fungi, the coincidence of hypersensitivity to both might be explained by assuming that many such vesicopustular eruptions start primarily as a fungus or yeast infection of the hands and/or feet, to which the skin in these areas becomes sensitized. Subsequent "flare-ups" of these sites might then be initiated by the theoretically related allergenic factors contained in the bacterial toxins, or products elaborated in endogenous, or other remote foci of infection. This concept derives some support from Jodassohn's[35] finding, that even among unrelated fungi an allergenic principal is found that is common to all.

If this theory were correct, more satisfactory and more permanent desensitization should be accomplished by the use of combined fungus and/or yeast vaccine, and the particular bacterial extracts to which the individual is found to be sensitive.

Our results with the use of such combined vaccines is shown in the accompanying summary.

SUMMARY OF INVESTIGATIONS AND TREATMENTS

| | | |
|---|---|---|
| Number of patients studied and treated | 27 | |
| Average age of patients in years | 35 | |
| Average number of years patients had been having recurrent eruptions | 2.5 | |
| History of previous "athlete's foot" | 64 | % |
| History of possible foci of infection | 57 | % |
| Occurrence of positive Intradermal Tests: (2 plus to 4 plus reaction) | | |
| To Respiratory Tract Bacterial Vaccine | 83 | % |
| To Fungus and Yeast Vaccines | 82 | % |
| To Staphylococcus Vaccine | 67 | % |
| To Streptococcus Vaccine | 30 | % |
| Average number of intradermal injections of bacterial vaccine combined with fungus or yeast extract given to each patient | 16 | |
| Average amount of improvement from injection according to patient's statement | 80 | % |
| Number of patients having relapses | 25 | % |
| Failure to obtain any benefit | 14 | % |

33. Goodman, H., and Marks, I.: Reactions to Trichophytin Compared with Reactions to Other Bacterial Products. Arch. Dermat. & Syph., 31:819. June 1935.
34. Graham, T. N., and Traub, E. F.: Allergic Bacterial Dermatoses. Arch. Dermat. & Syph., 34:485. 1936.
35. Jodassohn, W., and others: Analysis of Composite Antigens by Schultz-Dale Technique: Further Experimental Analysis of Trichophytins. J. Immunol., 32:203. 1937.

MISCELLANEOUS GROUP

Nervous exhaustion and fatigue has long been a favorite hypothesis to explain these sudden outbreaks. It was Becker [4] who first gave a rational explanation of this phenomena by finding that injections of Mecholyl could produce or aggravate these eruptions. It is his belief that in the individual with a low blood pressure, and an abnormal freedom from the sensation of ever becoming tired, that the products of fatigue are perverted from their normal paths, and transmitted to the nerve ends, where they release acetyl-choline. These patients do well on frequent periods of enforced rest, small repeated daily dosages of sedatives, generalized ultra-violet therapy, and mild, soothing preparations locally.

The recurrent outbreaks which occur primarily during the summer or appear only when in hot humid climates can usually be diagnosed by history alone, and respond rapidly to two or three fractional superficial x-ray treatments. Careful studies should be made to exclude the possibility of direct fungus or bacterial infections or their resulting "ids", as their innoculation and growth are favored by similar climatic conditions.

The diagnosis of idiopathic recurrences of vesicopustules should be reserved for those cases in which all known etiologies have been excluded, a period of hospitalization has removed the individual from sources of contact irritants, all possible laboratory therapeutic tests have proved normal, and any underlying fatigue symptoms or functional neurosis has been corrected.

SUMMARY

1. A plan is outlined which will be of help in determining the cause, initiating appropriate therapy, and preventing future recurrences of vesiculopustular eruptions of the hands and feet.

2. The oral use of sulfathiazole or sulfadiazine in gradually increasing daily dosages is a rapid method of discovering in which patients the eruption is due solely to the effects of bacteria or their products.

3. The theory is advanced that in many patients, bacteria, their toxins, or products from endogenous foci may activate recurrent vesiculopustular eruptions in areas of skin which previously have been infected by, or sensitized to fungi. In these cases the vaccines used in desensitization should include both fungus and/or yeast, combined with extracts of the sensitizing bacteria.

The opinions or assertions contained herein are the private ones of the writer, and are not to be construed as official or reflecting the views of the Navy Department or the Naval Service at large.

## RADIO AND PATENT MEDICINES

As an example of the radio operator's problem, we recently turned down a program advertising a notorious patent medicine which has been exposed as worthless. The account, representing $25,000 a year, went to another station. We had incurred the ill-will of an advertiser and an advertising agency—without accomplishing anything that would tend to raise the standards of patent medicine advertising.

Our unsuccessful efforts to improve such a condition are worth recounting. First, we approached the New York Academy of Medicine. We asked to submit for their approval all medical and patent medicine advertising offered to us. In turn, should the Academy disapprove a product, we asked permission to state the fact to the advertiser and the advertising agency as justification for our refusal to accept it. After several long discussions, the Academy officials said that they could give us general advice but that they could not assume the kind of responsibility implicit in the agreement which we proposed.

We then appealed to the United States Public Health Service. They told us that, because of their diversified responsibilities, they could not participate in such a project.

Our experience points, I think, to the need for a plan that will assure listeners that any statement made on the air about a medical product may be accepted without reservation. This would seem to require the participation of an outside institution of admitted competence and unquestionable integrity. — Nathan Straus, N. Y. Times, June 3, 1945.

# NEUROPSYCHIATRIC SCREENING OF SELECTIVE SERVICE REGISTRANTS IN NEW JERSEY *

Emil Frankel
Director, Division of Statistics and Research
New Jersey Department of Institutions and Agencies, Trenton

The knowledge gained during World War I of the types of individuals best adapted for combat duty, and the experience gained in that war in the recognition and avoidance of neuropsychiatric casualties, led the National Selective Service System early in World War II to provide for the psychiatric examination of all candidates for induction so as to identify individuals who are emotionally unadapted for military service and to facilitate the exclusion of individuals who are likely to break and to become potential sources of contagious disturbance in the military unit.

As stated in one of the early announcements of the present Selective Service System, examining physicians were urged "to make every effort to prevent induction of borderline psychiatric cases—those whose morale is likely to break down when they are moved from their customary environment. Such men are particularly troublesome in military service. They disturb morale and discipline. They spend most of their time in hospital beds while in the Army and after they are out of the service. The Government has to take care of them and they cost the public huge sums of money." [1]

## EXTENT OF NEUROPSYCHIATRIC REJECTIONS

On the basis of two national sample studies conducted by the Selective Service System some conception may be had of the extent of rejections of selective service registrants for the various mental disorders:

| Defect or Defect Group | Selective Service Registrants: Number of Registrants Rejected per 1,000 Examined, All Ages | 18 and 19 Year-Olds |
|---|---|---|
| *Mental diseases* | 76.4 | 27.6 |
| Grave mental or personality disorder | 4.9 | 3.5 |
| Major abnormalities of mood | 2.1 | 0.7 |
| Psychopathic personality | 22.2 | 7.5 |
| Psychoneurotic disorders | 44.0 | 15.2 |
| Chronic inebriety and drug addiction | 2.3 | ** |
| Mental disease not classified elsewhere | 0.9 | 0.7 |

** Less than 0.05 per thousand

In addition to these rejection rates for mental diseases, the rejection rates for neurological defects must be considered, which were 21.0 per 1,000 of all ages examined and 14.8 per 1,000 of the 18- and 19-year-olds.

The rejection rates in World War II are nearly five times as high as the rejection rates for similar causes during World War I and six times as high as the rejection rate for "Diseases of the Nervous System" during the Civil War draft.

| War | Registrants Rejected for Neuropsychiatric Reasons Per 1,000 Examined |
|---|---|
| World War II | 97.4 * |
| World War I | 21.0 ** |
| Civil War | 16.2 *** |

* Based on sample studies made by Selective Service System.
** "Neuropsychiatry in the United States", the Medical Department of the U. S. Army in the World War, Government Printing Office, 1929.
*** "Statistics, Medical and Anthropological, of the Provost-Marshal-General's Bureau", vol. 11, Washington, Government Printing Office, 1875.

While it is exceedingly difficult to make valid comparisons of the practices in the three wars, because of the progress in medical and psychiatric knowledge during the past eighty years, it seems reasonable to assume that the much higher frequency of neuropsychiatric re-

* Paper presented at Symposium on Current Trends in Mental Diseases, American Psychopathological Association, New York City, June 9, 1944.

1. "Selective Service", Washington, D. C., January 1, 1941. See also illuminating article on "Psychiatric Problems in the Army" by Lt. Col. William C. Menninger, the Journal of the American Medical Association, November 20, 1943.

jections in the present selective service program stems from the determination that no commander of an American Expeditionary Force will find it necessary to repeat the complaint expressed in General John J. Pershing's cablegram of July 15, 1918, quoted herewith:

> Prevalence of mental disorders in replacement troops recently received suggests importance of intensive efforts in eliminating mentally unfit from organizations new draft prior to departure from the United States.[2]

## THE NEW JERSEY SCREENING PLAN

To make sure that psychiatric examiners had ample material on which to evaluate the mental status of registrants, the New Jersey Selective Service System, along with other State and local service units, has endeavored to carry out instructions from the National Selective Service System to the effect that, "information should be sought from any source possible that bears on a history of mental disease in the family of registrant, or social maladjustment, poor work record, other mental or personality disorders of the registrant, or any physical condition which might cause the armed forces ultimately to reject the registrant".

In this connection it was widely felt, in the light of the experience in psychiatric clinic work, that the examining psychiatrists would be definitely aided in arriving at their decisions, to accept or reject individual registrants, if they could have before them at the time of interview an analysis of records indicating mental inadequacies previously noted in the lives of the registrants.

In New Jersey, the State Department of Institutions and Agencies and a committee of the New Jersey Chapter of the American Association of Social Workers have collaborated with the Selective Service System of New Jersey in developing a statewide neuropsychiatric screening system to provide the examining psychiatrists with information about the prior institutional and other social histories of registrants which might be helpful in making accurate psychiatric appraisals of military fitness.[3]

The Central Index of the Department furnishes histories and the outcome of previous stays in mental hygiene and penal and correctional institutions, tuberculosis preventoria and sanatoria. This source also provides identifying data concerning individuals registered with the Department and waiting to be admitted to institutions for the mentally deficient or epileptic, and individuals presenting social or mental problems in the community about whom inquiries have been made of the Department, but who have not been institutionalized.

The social and health workers in the local communities, aided by social service exchanges (a) supplement the information furnished by the Central Index with information from the community, and (b) furnish available community information alone if no record has been discovered in the Central Index Record.

## TYPE OF INFORMATION FURNISHED

The following samples will indicate the type of information made available to the psychiatrists at the two Induction Stations in New Jersey to be used by them in the examining process:

> Case No. 1—Central State Index Information: Committed to New Jersey State Hospital 1936. Diagnosis on admission: Alcoholic psychosis—acute hallucination type. Paroled 1936. Discharged 1937. Condition on discharge: recovered.
>
> Case No. 2—Central State Index Information: Committed New Jersey State Prison 1939. Assault and battery. Paroled 1940. Recommitted to State Prison 1941 for assault and battery. Discharged 1943, expiration of maximum sentence. Psychiatric: Constitutional inferior with episodes (1941). (Evidently subject had auditory and visual hallucinations at time of examination.) Was under observation prior to prison commitment. Psychological: Feebleminded, moron.
>
> Case No. 3—Central State Index Information: Admitted tuberculosis sanatorium 1932. Diagnosis on admission, moderately advanced. Discharged 1934. Condition on discharge, apparently arrested. Community information: Mental hygiene clinic examination 1933 requested because he was somewhat of a behavior problem at tuberculosis sanatorium. Home broken—mother dead, father deserted.
>
> Case No. 4—Central State Index—No record. Community information: School report—better than average school work; took agriculture course; failed physical education, cooking and bookkeeping; likable but very irresponsible; very artistic; definitely tied to his "mother's apron string"; mother did his thinking for him while he was in school.

2. "Neuropsychiatry in the United States", the Medical Department of the United States Army in the World War, Washington. Government Printing Office, 1929.
3. For details see "Handbook for Guidance of Social and Health Counsellors—Selective Service System of New Jersey", August, 1943.

Case No. 5—Central State Index—No record. Community information: Unstable personality. Repeatedly before court for larceny and receiving; assault and battery, bodily assault; attempting to rob, seizing pocketbook. He presented school problems over a long period.

## SOME STATISTICS OF RESULTS OF STATE CENTRAL INDEX SCREENING

During the last twelve months the names of 108,000 individual registrants were checked against the Central Institutional Index of the State Department of Institutions and Agencies.[4] Institutional records were found for 2624 registrants, equivalent to 2.43 per cent of the total.

In addition to the 2624 identified registrants with institutional records there were 141 registrants identified about whom inquiries had been made in the Department for consideration for admission to state institutions because of mental or behavior problems.

The results of the screening of these 108,000 names of selective service registrants with the Central Index of state and county institutions showed that of each 10,000 selective service registrants 243 have been in some type of institution during their lives, 27 of them in a mental disease hospital and 7 in an institution for the mentally deficient.

| Individual Registrants | Institutional Records Rate per 10,000 Selective Service Registrants |
|---|---|
| All types of institutions | 243 |
| With mental disease hospital background | 27 |
| With mental deficiency institution background | 7 |
| With adult correctional institution background | 119 |
| With juvenile delinquency institution background | 34 |
| With tuberculosis sanatoria and preventoria background | 56 |

## SOCIAL SERVICE EXCHANGE FINDINGS

The names of 1500 selective service registrants checked by one local social service exchange revealed that more than 12 per cent were known to local social and health agencies as having received their services as individuals, and an additional 40 per cent were identified as having had service contacts as a part of a family unit. Altogether *more than half of the selective service registrants*—either they themselves or their families—had previous social and health agencies contacts.

It should be pointed out, however, that while the number of identifications of the families and registrants in the social service exchange was sizeable, the actual number of families or registrants having social and health agency contacts which might have neuropsychiatric implications was not quite so significant.

In summary it might be said that the experience of the screening program in New Jersey during the last twelve months has shown that community information of a significant nature from the standpoint of neuropsychiatry has been made available for from 10 to 15 per cent of the total selective service registrants considered for induction.

## RESULTS OF NEUROPSYCHIATRIC SCREENING

The prime purpose of the neuropsychiatric screening program was to gather and furnish information to the examining psychiatrists at the Induction Stations which would help them in determining the fitness of the registrant for active military service and to exclude those who showed possible signs of future physical or mental breakdowns, or probable failure to adjust themselves to the exacting demands of military service. It is of interest, therefore, to have the opinon of the Selective Service System as to the value of the program.

The Chief of the Medical Division records himself as follows:

A review of all registrants examined at New Jersey Induction Stations during a 3½ months' period in 1943 disclosed that positive neuropsychiatric data submitted were instrumental in the rejection of 45 per cent of that group on whom positive data were found in the various agencies.

It has been a source of considerable satisfaction to note the progress of the plan in New Jersey and to see the recognition of the value of such a plan by the entire system. According to a statement by Major General T. A. Terry, Commanding General of the Second Service Command, the plan has assisted the Induction Station examiners to detect and reject registrants manifesting undesirable neuropsychiatric traits. He pointed out the likelihood of future economic benefits to the State of

4. Work carried on by the staff of the Division of Statistics and Research with the cooperation of the Division of Education and Classification, under the general supervision of the late Commissioner William J. Ellis.

New Jersey through the prevention of mental breakdown of borderline psychiatric cases whose induction was prevented through the operation of the medical survey.

An indication of the potential value of the present psychiatric screening program may be had from the experience of World War I in the incidence of neuroses among three of the expeditionary forces:

| Expeditionary Force | Designation | Rate per 10,000 Casualties |
|---|---|---|
| American | Functional nervous disease | 9.5 |
| Canadian | Nervous and mental disease | 24 |
| British | Neuroses | 34 |

The definitely lower incidence rate among the American Expeditionary Force was attributed in a British study, "to the attempt to eliminate potential neurotics from the American Expeditionary Force" although it is emphasized that *"its comparatively short period of service" should also be taken into account in comparing these figures.*[5]

A further observation may be made that this whole experiment in utilizing state welfare and health organizations and community agency sources for material or the medical and social background of selective service registrants offered opportunity to use effectively the data which has been accumulated by the social and health institutions and agencies (public and private—state and local) in their efforts to aid individuals in need of their services and to show the value of the skills and experience of the various social and health workers in guiding and administering the fact-gathering program.

## SOME OBSERVATIONS ON SCREENING PROBLEMS

The figures presented in the foregoing pages indicate that many more registrants have been rejected for neuropsychiatric causes than have been identified through the screening program as having histories of institutional care or community treatment for reasons justifying their exclusion from the armed forces. This was to be expected for there are many individuals who have been able to adjust to civilian life who display traits which, to the psychiatrist, suggest unfitness to withstand the stresses and strains of military life.

It need not be pointed out that the selection of individuals vocationally adapted for service in the armed forces and the exclusion of those who are manifestly unsuited, is fraught with great difficulties.

Thus a well-known psychiatrist discussing the psychiatric problems faced by the services declared that "no one is immune to stress", particularly if that stress is intensified by aging, disease, or exposure to climatic, nutritional and other hygienic hazards. "It is for this reason," he said, "that the psychiatrist can hardly be reproached for not excluding from the Army all those who may break; if he did so there would be no Army."[6]

The National Selective Service itself is fully conscious of the problems created by the rejection of large numbers of men, when so many are urgently needed in the rapid development of America's fighting forces.

"An ever recurring task has been the study of the defects of men rejected for military service and their prospects for acceptance under actual or proposed changes in physical standards," declared an official of the Selective Service. "To date most attention has perhaps been given to rejections for educational deficiency, venereal disease, teeth, psychoneurosis, eyes and ears. Regarding syphilis and teeth, considerable progress has been made in getting standards revised for the acceptance of men with these defects. Since the number of these rejections aged 18 through 37 has now reached 3,500,000 and fathers are being drafted, the importance of the subject has caused Congress to legislate for a five-man medical board to study the physical standards of the Army and Navy."[7]

The President's Commission appointed on December 30, 1943, expressed concern over the number of neuropsychiatric disabilities, "particularly those occurring in the first six months of service". The Commission said it had been informed by the Administration of Veterans Affairs that "any lowering of the

5. "The Neuroses in War", by several authors under the editorship of Emanuel Miller, The MacMillan Company, New York, 1942.
6. Dr. Winfred Overholser, quoted in New York Times, March 12, 1944.
7. "The Statistical Program of the Selective Service System", by Kenneth H. McGill, Journal of the American Statistical Association, March, 1944.

requirements for admission to the armed forces could be expected to increase the admission rate to facilities of the Veterans Administration".

It is much better for "potential neuropsychiatric casualties" to be rejected at induction stations than to be taken into the Army or Navy and discharged later, said the report. The Army and Navy showed willingness, the Commission stated, to provide training, remedies and correctives to qualify for fighting men with certain defects. But, it concluded, "in view of the mission of the services to prosecute the war, there is a point beyond which they should not go in expending time or personnel and use of training facilities for the possible salvage of individuals of very doubtful future value to the services".

Navy representatives stressed the importance in sea duty of physical and mental fitness. Every man on a combat vessel, regardless of his regular duties, must be able to perform "combat duties under conditions requiring a high degree of coördination and teamwork". Anything short of perfect performance could not be tolerated, it was emphasized.[8]

### REHABILITATION OF REJECTED SELECTIVE SERVICE REGISTRANTS

Another phase of psychiatric service associated with the operation of the Selective Service System is to help rehabilitate or retrain registrants rejected for psychoneurotic reasons.

The social and health workers who come in close contact with selective service registrants at the induction stations or at the local draft boards soon realized that provision must be made to furnish mental hygiene and social work services for a number of individuals who were rejected for military service because they would probably be unable to adjust to the rigors of military training and who have not since made satisfactory personal and community adjustment.

Inasmuch as a majority of those individuals rejected for military service for neuropsychiatric reasons were able to function fairly satisfactorily in the social and economic environment of their own communities, and in their customary family life before they came under consideration for military service, they may be expected to readjust in their own spheres without serious difficulties.

There is, however, another group of rejected men who already show symptoms of mental instability whose rejection may have disturbed their equanimity and morale to such an extent that they are in need of mental hygiene services.

Through the coöperation of the Northern New Jersey Mental Hygiene Clinics, a demonstration study of a representative sample of selective service registrants was undertaken to find out what were the underlying reasons for their rejection and whether any of them was in need of psychotherapeutic services.

Of 618 individuals referred to the psychiatric social worker at the induction station in Newark, 68 per cent were referred for treatment for either reclassification or rehabilitation, 23 per cent for investigation for documentary evidence of claimed mental and emotional disabilities, 8 per cent because of borderline conditions for which there should be some community awareness and interpretation, and one per cent presented institutional problems.

Those in need of psychotherapy were referred to the volunteer social and health counsellors attached to the local draft boards to make the arrangements for appropriate mental hygiene service. Experience has shown that facilities for psychotherapeutic services would have to be very much enlarged to take care of this greatly augmented load.

### VETERANS' REHABILITATION PROGRAM

The steady increase in the number of men and women returning from various types of military service to take their places in civilian life makes it imperative that we prepare the ground for them back in their home communities in a manner which will reflect the same ingenuity and enthusiasm that we displayed in organizing ourselves for war.

Among the members of the armed forces already returning are a considerable number discharged for neuropsychiatric reasons, that is, individuals who have suffered mental breakdowns of various severities which will need the

8. New York Times, February 29, 1944.

application of a variety of rehabilitative measures—psychiatric, occupational, economic and social.

The neuropsychiatric aftermath of World War I and World War II to date is reflected in 316,121 admissions of veterans to federal neuropsychiatric facilities in the 21-year period 1923 to 1943. On June 30, 1943, there were 36,414 veterans in neuropsychiatric Veterans' Administration Facilities as against 20,157 ten years ago. The proportion of non-service connected veterans of the total number was 44 per cent in 1933 and 67 per cent in 1943.

As a result of World War II, more than 4,400 veterans have already been admitted to neuropsychiatric facilities of the Veterans' Administration up to June 30, 1943; of these 54 per cent were service connected and 46 per cent non-service connected.

The rehabilitation of veterans is expected to be primarily the responsibility of the Federal Government. The mental casualties of World War I resulted in the creation of Federal hospital programs which had to be continually expanded as the need increased.

It is clearly evident, however, that the provision of additional hospital facilities is only a partial answer. In addition to those requiring hospitalization many more men and women discharged from the armed forces for neuropsychiatric reasons will present problems not requiring hospital care, but will require mental hygiene services in their respective communities.

We must see to it therefore that the Federal Rehabilitation Program for the veteran suffering from a mental ailment includes a variety of services which should be prepared in advance and readily available in the community to help in his speedy social and economic readjustment. These services will have to include psychiatric consultations by private psychiatrists or in mental hygiene clinics, vocational training or retraining, employment counselling and placement and such other economic and social service assistance as will help him take his place as a productive citizen in his community.

There are strong signs that we are fully cognizant of the problems and needs of the returning soldiers and of selective service "rejectees". Many health and welfare organizations are already enlarging their services and facilities so as to be prepared to meet the increase in veterans' rehabilitation needs generally, and the needs of mental cases particularly. What is important now is that these many and varied organizations study their resources and possibilities so as to gain a thorough understanding of what service each is capable of rendering and how their activities may be dovetailed with each other to render the most effective all-round service.

## CARCINOMA AND DIGITAL RECTAL EXAMINATION

Digital examination exceeds and precedes in importance all other methods of examination for carcinoma of the lower sigmoid and rectum. Proctoscopy, sigmoidoscopy and x-ray examination are at times necessary but are refinements in technique. In contrast, digital examination is simple and available at all times to the physician. There is no excuse for omitting it when the patient complains of rectal bleeding. It is of more value in the diagnosis of malignancy of the rectum than any other one procedure.

The condition may often be detected by digital examination and missed by other methods in unskilled hands. With the patient in the left lateral Sims position, hips well out on the edge of the examining table, the average index finger can easily palpate the majority of rectal lesions. There is rarely any contraindication to this type of examination.

Digital rectal examination is the most important, the most informative and the most indispensible of all the methods employed by proctologists to determine the presence of carcinoma of the rectum. Physicians will save themselves much grief by utilizing it regularly. —J. Gerendasy, M.D., Elizabeth, N. J.

# STATE ACTIVITIES

## NUTRITION IN EVERYDAY PRACTICE

S. WILLIAM KALB, M.D., Newark, N. J.
Nutrition Representative, Tuberculosis and Adult Disease Control Advisory Committee to the Subcommittee on Public Health

1. *What is the best beverage to control thirst?* Iced tea with lemon. Tea and lemon are diuretics. They also have a diaphoretic action.
2. *How is fat formed in the body from carbohydrate intake?* The metabolic transformation occurs by conversion of Pyruvic acid (from glucose) to Acetaldehyde. This is converted to Aldol and finally to Butyric acid (fatty acid).
3. *In what percentage should the food stuffs be distributed in a diet to maintain normal health?* Proteins 15 per cent, Fats 15 per cent, and Carbohydrates 70 per cent.
4. *What is meant by trace elements in nutrition?* These are elements found in animal tissues in very small amounts. The trace elements essential to life are: copper, cobalt, bromine, aluminum, fluorine, manganese, and zinc.
5. *How do some cheeses compare with butter in fat content?* Cottage cheese, a product of skim milk, contains 1 per cent fat, cream cheese 38 per cent, cheddar 36 per cent, Swiss cheese 35 per cent, and American cheese 31 per cent. Butter contains 85 per cent fat.
6. *What foods are high in calcium?* In order of decreasing percentage, they are:

| | |
|---|---|
| TURNIP TOPS | CAVIAR |
| MILK, COW'S, CONDENSED | EGG-YOLK |
| HAZEL NUTS | BEANS, KIDNEY, DRY |
| ALMONDS | GOAT'S MILK |
| MOLASSES | BOSTON BROWN BREAD |
| FIGS, DRY | CAULIFLOWER |
| SWISS CHARD | SOFT CLAMS |
| MILK, COW'S, WHOLE | ROUND CLAMS |
| COCOA | BUTTERMILK |
| LENTILS, DRY | DANDELION GREENS |
| MAPLE SYRUP | ENDIVE |

7. *Are there any contraindications to the use of saccharin?* There are no contraindications nor any harmful effects from its use. The average dose is ¾ grain.
8. *What therapy is advised during pregnancy to provide good nutrition in the mother and fetus?* In the second and third trimesters of pregnancy the diet must be regulated and balanced carefully to prevent any damage to the tissues. Medication should be as follows:
   During the first trimester—
   ℞ Vitamin A ..... 10,000 units
   Thiamin ..... 5 mg.
   Ascorbic Acid .... 25 mg.
   S. D.T.D. once a day.
   Double this dose during the second trimester. Triple this dose during the third trimester.
9. *Is the treatment in Lupus Erythematosus with vitamins of any value?* Intramuscular injections of 0.1 gm. of nicotinic acid amide usually produces striking results. The itching, burning and the hyperkeratotic scales recede rapidly within a few days.
10. *Is dysmenorrhea relieved by any vitamins?* No. But effective and quick relief may be obtained by injection of Depropanex 2 cc. two or three times a day. This is a deproteinated pancreatic extract.

## SUPPLEMENTARY LIST OF MEMBERS NO. 2

The figures in parentheses refer to County Societies as follows: (1) Atlantic, (2) Bergen, (3) Burlington, (4) Camden, (5) Cape May, (6) Cumberland, (7) Essex, (8) Gloucester, (9) Hudson, (10) Hunterdon, (11) Mercer, (12) Middlesex, (13) Monmouth, (14) Morris, (15) Ocean, (16) Passaic, (17) Salem, (18) Somerset, (19) Sussex, (20) Union, (21) Warren.

Adler, Hubert J., 91 Morris av., Phillipsburg (21)
Allen, Raymond N., 144 Harrison st., E. Orange (7)
Bass, Rose D., 54 Lyons av., Newark (7)
Brancato, Peter, 93 E. 38th st., Paterson (16)
Bronner, Alfred, 95 Jackson st., Passaic (16)
Cioffi, Eugene, 137 Belvidere st., Washington (21)
Cogan, Henry, 123 Depew av., Buffalo, N. Y. (16)
Conlon, Philip J., 25 James st., Newark (7)
Cuccinella, Anthony B., 361 Lafayette st., New'k (7)
Denholtz, Emanuel, 16 Harrison pl., Irvington (7)

Fabriele, John B., 1112 Boulevard, Bayonne (9)
Graham, Richard B., ARMY
Halbeisen, William A., 511 Cooper st., Camden (4)
Harrington, Walter L., 104 S.Munn av.,E.Orange(7)
Hershey, Harry H., 921 Bergen av., Jersey City (9)
Ivey, Evelyn P., Lake Valley rd., Morristown (14)
Jensen, Grover H., 451 Bergen av., Jersey City (9)
London, Leslie, 120 Lexington av., Passaic (16)
Makarchek, Sigmund J., 289 Broad st., Bloomf'ld(7)
McLaughlin, Thomas F., 596 Main st.,Metuchen(12)
Miller, Robert M., 382 Springfield av., Summit (20)
Norris, Alfred W., 123 Prospect st., Paterson (16)
Perrone, Anthony J., 456 Roseville av., Newark (7)
Reilly, Joseph B., 604 White Horse Pike, Oaklyn(4)
Rose, Salvatore J., 242 Ivy court, Orange (7)
Rossi, John R., 119 W. 36th st., Bayonne (9)
Roth, Samuel R., 31 Lincoln Park, Newark (7)
Schmukler, Jacob, 16 Johnson av., Newark (7)
Sheehan, Edward G., 7807 Park av., N. Bergen (9)
Siegler, Julius, 646 Bergen av., Jersey City (9)
Sivolella, Nicholas A., 245 Clifton av., Newark (7)
Stark, Harry L., 680 Boulevard, Bayonne (9)
Thompson, Edna Riedel, Flanders (14)
Wegrocki, Adolph A., 588 Sanford av., Newark (7)
Weitz, Abraham, 39 S. 21st st., Kenilworth (20)

ASSOCIATE MEMBERS

Alexander, J. W., 227 Main st., Orange (7)
Firtel, Saul I., 764 Scotland rd., South Orange (7)
Kimche, Irwin, 18 Wittkop pl., Millburn (7)
Lohman, Herman, 91 Spruce st., Newark (7)

# OBITUARIES

## DR. RUBIE EPSTEIN

Dr. Rubie Epstein of Trenton died on July 28, following a brief illness.

Dr. Epstein was born in Asbury Park in 1898 and studied medicine at Hahnemann Medical College, Philadelphia, receiving his medical degree in 1924.

Dr. Epstein was on the staff of McKinley Hospital and was a member of the Mercer County Medical Society, The Medical Society of New Jersey and the American Medical Association.

## LT. COMDR. HOWARD B. MASON

Lieutenant Commander Howard B. Mason, prominent physician of Freehold, died on July 14, 1945, in the Naval Hospital at St. Albans, L. I., of a heart ailment suffered while on duty in the South Pacific.

Commander Mason enlisted in September, 1942, and after receiving training at Norfolk Naval Hospital, was sent to the South Pacific in October, 1943. He saw action at Leyte and Iwo Jima and a short time later suffered a heart attack. He was removed to a hospital at New Caledonia and was returned to this country on May 16.

Commander Mason was born in 1900. He was a graduate of Lehigh University and Syracuse University and completed his medical studies at Post Graduate Hospital in New York City. He was a fellow of the American College of Surgeons, was on the staff of the Fitkin Memorial Hospital at Neptune, and was a former member of the Board of Education.

Commander Mason was a member of the Monmouth County Medical Society, The Medical Society of New Jersey and the American Medical Association.

## DR. JOHN A. QUIN

Dr. John A. Quin, president of the staff of the Rahway Memorial Hospital, died on June 30, 1945, at the hospital.

Dr. Quin was born in Carteret in 1906. He was a graduate of Rahway High School and Manhattan College and received his medical degree from Temple University School of Medicine in 1934. He interned at St. Joseph's Hospital, Yonkers, N. Y., and began his medical practice in Rahway nine years ago.

Dr. Quin was a junior assistant surgeon at St. Elizabeth Hospital, Elizabeth, and a member of the surgical staff of Elizabeth General Hospital. He was a member of the Union County Medical Society, The Medical Society of New Jersey and the American Medical Association. Dr. Quin was a medical consultant to the Union County Mental Hygiene Society, a member of the Medical Advisory Committee of the Rahway Red Cross Nursing Service and belonged to the Academy of Medicine of Northern New Jersey.

## DR. GORDON F. WEST

Dr. Gordon F. West of Merchantville died of an acute heart attack on July 26, 1945, in Cooper Hospital. He had been in ill health for two years and recently returned from an extended stay in Tucson, Arizona.

Dr. West was born near Durham, N. C., in 1893. He was graduated from Trinity College, now Duke University, in North Carolina, and entered the University of North Carolina where he studied medicine for two years. He then transferred to Jefferson Medical School, receiving his medical degree in 1919.

Dr. West served his internship at Cooper Hospital in Camden in 1920 and 1921 and became a staff member in 1922. He was widely known in obstetrical and gynecological work, having been assistant to the chief of those departments at the hospital.

He was a Fellow of the American College of Surgeons, a Diplomate of the American Board of Obstetricians and Gynecologists, president of the Camden County Medical Society, and a member of The Medical Society of New Jersey and the American Medical Association.

# CONSTRUCTIVE PROGRAM FOR MEDICAL CARE

## AMERICAN MEDICAL ASSOCIATION

**This platform was adopted by the Council on Medical Service and Public Relations and the Board of Trustees of the American Medical Association on June 22, 1945.**

### Preamble

The physicians of the United States are interested in extending to all people in all communities the best possible medical care. The Constitution of the United States, the Bill of Rights and the "American Way of Life" are diametrically opposed to regimentation or any form of totalitarianism. According to available evidence in surveys, most of the American people are not interested in testing in the United States experiments in medical care which have already failed in regimented countries.

The physicians of the United States, through the American Medical Association, have stressed repeatedly the necessity for extending to all corners of this great country the availability of aids for diagnosis and treatment, so that dependency will be minimized and independence will be stimulated. American private enterprise has won and is winning the greatest war in the world's history. Private enterprise and initiative manifested through research may conquer cancer, arthritis and other as yet unconquered scourges of humankind. Science, as history well demonstrates, prospers best when free and unshackled.

### Program

The physicians represented by the American Medical Association propose the following constructive program for the extension of improved health and medical care to all the people:

**1. Sustained production leading to better living conditions with improved housing, nutrition and sanitation which are fundamental to good health; we support progressive action toward achieving these objectives:**

**2. An extended program of disease prevention with the development or extension of organizations for public health service so that every part of our country will have such service, as rapidly as adequate personnel can be trained.**

**3. Increased hospitalization insurance on a voluntary basis.**

**4. The development in or extension to all localities of voluntary sickness insurance plans and provision for the extension of these plans to the needy under the principles already established by the American Medical Association.**

**5. The provision of hospitalization and medical care to the indigent by local authorities under voluntary hospital and sickness insurance plans.**

**6. A survey of each state by qualified individuals and agencies to establish the need for additional medical care.**

**7. Federal aid to states where definite need is demonstrated, to be administered by the proper local agencies of the states involved with the help and advice of the medical profession.**

**8. Extension of information on these plans to all the people with recognition that such voluntary programs need not involve increased taxation.**

**9. A continuous survey of all voluntary plans for hospitalization and illness to determine their adequacy in meeting needs and maintaining continuous improvement in quality of medical service.**

**10. Discharge of physicians from the armed services as rapidly as is consistent with the war effort in order to facilitate redistribution and relocation of physicians in areas needing physicians.**

**11. Increased availability of medical education to young men and women to provide a greater number of physicians for rural areas.**

**12. Postponement of consideration of revolutionary changes while 60,000 medical men are in the service voluntarily and while 12,000,000 men and women are in uniform to preserve the American democratic system of government.**

**13. Adoption of federal legislation to provide for adjustments in draft regulation which will permit students to prepare for and continue the study of medicine.**

**14. Study of postwar medical personnel requirements with special reference to the needs of the veterans' hospitals, the regular army, navy and United States Public Health Service.**

# COUNTY SOCIETY REPORTS

## CAPE MAY COUNTY

C. W. Way, M.D., Reporter

A regular meeting of the *Cape May County Medical Society* was held on Tuesday evening, June 12, 1945, at 9:00 p.m., at Fred's Restaurant, Cape May Court House, with DR. GEORGE BROOKS, President, presiding. Harmony between the County's medical profession and the Burdette Tomlin Memorial Hospital project was expressed when members of the Hospital Foundation and their guests were entertained by the County Medical Society. The meeting was preceded by a steak dinner.

The physicians pledged full coöperation in the building and staffing of the proposed new hospital at the County seat. There is $142,528 in the Foundation Fund. In addition the Fund is to receive $50,000 from the John Cobb estate.

DR. DAVID B. ALLMAN, Chief Surgeon of the Atlantic City Hospital, was the principal speaker. He said that it was fine and proper for the doctors to take an interest in the hospital, and declared, "No matter how much money you have, the hospital will be just a mass of bricks and straw and equipment unless you have the full coöperation of nearly every one in the County. Without their cooperation the hospital could not be conducted successfully if two million dollars were raised for its construction. Once the hospital is in operation it will be worth all the headaches experienced in working for it. Before going further, the Hospital Foundation should employ an architect specializing in hospital design to assure maximum of layout and efficiency in structure."

JUDGE FRENCH B. LOVELAND, a member of the Board of Governors, said that the Board seeks cooperation of all the doctors in the County. The advice and asssitance of the Medical Society is needed as the success of the project will depend upon the doctors.

Other speakers were: Dr. Joseph Dillenberg, New York City; Prof. Edward F. Jefferson of Hotchkiss School, Lakeville, Conn.; Dr. Alex. Moon, Dr. Aldrich C. Crowe, Prof. Daniel Recker, Superintendent of Schools of Cape May County; Jesse D. Ludlow, Burton J. Smith, Dr. William Dodd and Joseph Millman, President of the Board of Governors.

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A meeting of the Woman's Auxiliary was held, Mrs. David B. Allman of Atlantic City, presiding. Mrs. J. Howard Hornberger of Roebling also attended the meeting.

Dr. William E. Dodd, Chairman of the Woman's Auxiliary Advisory Committee, made the following suggestions:

1. The President of the local County Medical Society should appoint an "organizer" from amongst the eligible doctors' wives of the county.
2. It shall be the duty of this organizer or temporary chairman to contact all eligible ladies in the county to ascertain their sentiments upon organizing a Woman's Auxiliary.
3. If sufficient interest is shown, this temporary chairman should call a meeting at which time officers of the Auxiliary should be nominated and elected.

Mrs. J. Howard Hornberger, Organization Chairman of the State Auxiliary, will be glad to attend this organization meeting and help with the installation of the officers.

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## UNION COUNTY

Joseph J. Labow, M.D., Reporter

The *Union County Medical Society* held its annual meeting at Muhlenberg Hospital, Plainfield, April 11, 1945, at 9 p.m. DR. BENSLEY, President, called the meeting to order and declared a quorum.

The minutes of the March 14th meeting and the Executive Committee meeting of April 9th were approved as read. The resolutions on the deaths of CAPTAIN O. F. CRANKSHAW, M.C., DR. W. J. ELLIS and DR. W. R. SMITH were read and accepted.

A letter received from the Union County Tuberculosis League was read. Because tuberculosis is often associated and manifests itself during pregnancy and because it still remains the leading cause of death for women of the child-bearing age, the League felt that a case-finding program in this group would be very worthwhile. It was suggested that a study be made of the problem by a committee from the League and advisory committee to the League. This was done, and at the Board Meeting on March 19th, it was voted that a committee present to the Union County Medical Society the following suggested plan, namely, that a study be made in the hospitals in Union County of prenatal and ward obstetrical cases, by having all patients within this group x-rayed at the hospital, the League bearing the cost of the x-rays, and that this committee, in conjunction with the Medical Advisory Committee, present this suggested program for finding tuberculosis to the Society. It was moved that the letter be received and filed.

It was moved that Miss Rogers be reappointed Executive Secretary.

Dr. Watson B. Morris read the ballot of the Nominating Committee and announced that DR. M. T. WEISSMAN had been nominated to serve on the Medical Service Bureau Committee replacing DR. BARON, who has moved to North Plainfield. It was moved that the ballot be accepted as read and the Secretary cast a unanimous ballot.

President, Walter F. Phelan
First Vice-President, Elton W. Lance
Second Vice-President, Stanton H. Davis
Secretary, Frederic W. Lathrop
Treasurer, George T. Banker
Reporter, Joseph J. Labow
Trustee, Elmer P. Weigel—1948
Board of Censors, Harry V. Hubbard—1950

Scientific and Literary Work Committee: Malcolm Edgar, C. G. Hanson and Ronald J. Walsh
Finance Committee: George A. Seymour—1948
Legislative Committee: W. B. Fort—1950
Medical Service Bureau Committee: M. T. Weissman—1949, C. G. Hanson—1949, J. A. Quin—1949, L. H. Salvati—1949, T. M. Morris—1949, J. D. Tidabeck—1949
Public Health Committee: Henry J. Konzelman—1950
Public Relations Committee: Abraham Rose—1950
State Nominating Committee: Thomas J. Walsh
Alternate: Frederic W. Lathrop
Delegates, term expires 1948: Elmer P. Weigel, H. V. Hubbard, C. H. Schlichter, J. J. Labow, George Knauer, Jacob Reiner
Alternates, term expires 1948: L. H. Leggett, S. H. Davis, A. R. Casilli, J. D. Tidabeck, F. A. Williams, R. J. Holland; 1947, Isaac Gelber

Dr. Banker, Treasurer, reported 1944 expenditures and read in detail the 1945 budget. Due to the illness of the County Society's auditor, the Finance Committee recommended that this report be received and that the auditor make his official report at a later meeting. It was moved that the Treasurer's report and budget be accepted.

The Executive Secretary announced that no committee reports would be made at this meeting but that the Annual Report of the Society would be published in the *Journal* of the State Society.

Dr. Bensley, as retiring President, gave an address in which he advocated the voluntary association of physicians in the various communities as a means of obviating the need for Federal or State-controlled medicine. Such associations of medical men could operate under present hospitalization and group protection plans and would be very flexible. They would eliminate the dangers of political control and lack of incentive feared in Federal or State control.

Dr. Phelan accepted the chair from Dr. Bensley and announced that a special meeting will be held at the Alexian Brothers Hospital, Elizabeth, on April 18th. The May meeting will be held in Summit on May 9th.

The meeting then adjourned.

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A special meeting of the Society was held at the Alexian Brothers Hospital, Elizabeth, on April 18, 1945.

Dr. P. S. Pelouze, Assistant Professor of Urology at the University of Pennsylvania, now serving as Special Consultant to the United States Public Health Service, discussed "The Diagnosis and Management of Gonorrhea". Dr. Pelouze stated that gonorrhea is more prevalent than ever before, especially in the army. He also discussed in detail the penicillin treatment for gonorrhea.

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A regular meeting of the Society was held at Ciba Pharmaceutical Products, Inc., Summit, N. J., May 9, 1945. The meeting was called to order by Dr. Phelan, President, at 9 p. m.

Dr. Phelan spoke a few words of welcome to several physicians from the Veterans' Administration, Lyons, N. J., who were present and extended to the doctors at the hospital a cordial invitation to attend all of the meetings of the County Society.

The minutes of the April 11th meeting and of the Executive Committee meeting of May 7th were read, corrected and approved.

Dr. Frederick M. Yonkman, Chief Pharmacologist of Ciba Pharmaceutical Products, Inc., was the speaker of the evening and discussed recent advances in medicine, chiefly in sulfa drugs and penicillin. Dr. Yonkman traced the transition of medicine from the stage when antiseptics were the chief pharmaceutical aids, to the present day of penicillin, so successfully used in the saving of lives both at home and on the battlefields.

He said that while penicillin was discussed by Fleming in England in 1928, its real development came as a result of the present war, because of the necessity for a strong curative power against infections. Dr. Yonkman presented slides of some of the first cases handled with the aid of penicillin.

He stated that at the beginning of the war, the United States was also much concerned because of the lack of a sufficient quantity of morphine. Scientists developed a synthetic product known as demerol, a formula introduced by German investigators. The synthetic product has certain advantages over morphine.

During the invasion of New Guinea, Dr. Yonkman said sulfaguanidine was successfully used by the armed forces to prevent dysentery, but in Normandy sulfasuxidine was found to be even more satisfactory.

Many questions were answered from the floor and highly appreciated.

A detailed discussion was held on the Monmouth County Medical Society Resolution. It was voted to accept the Monmouth County Resolution requesting that the State Society meeting include one delegate from each County.

Dr. Phelan reported that he had contacted several members of the County Society who expressed their willingness to serve on a joint cardiac committee. It was therefore moved that Dr. Phelan appoint Drs. A. F. Ackerman, Harry Bloch and Raphael Yood to serve on the joint cardiac committee with the Union County Tuberculosis League and the Visiting Nurse Association.

Dr. Ellen I. Sagi was introduced to the Society and signed the Constitution.

The meeting then adjourned.

# WOMAN'S AUXILIARY

## PRESIDENT'S MESSAGE

Mrs. William E. Dodd

The problems confronting the Woman's Auxiliary to The Medical Society of New Jersey today have not changed in the past year. We celebrated V-E day three months ago, V-J day we pray is near, but V-M day seems to be far away on the horizon. Victory for Medicine will mean the unhampered, non-political practice of medicine and will only be won by the united efforts of the medical families.

Just as empires have been built or destroyed as a result of someone's ability to interpret the straws in the wind so must we continue to see that the public understands clearly the full meaning of the bill which will bring Socialized Medicine. This can be accomplished so easily in your circle of friends and at your clubs, on your vacations and at home. The united support of the Auxiliary is just as necessary this year as it was in the past to insure security for the future.

The theme for 1945-46 is "Looking Ahead". It will not be long before the doctors who are in the service will be back with us again. Let us prepare then for their return by doing everything possible to make it a happy homecoming.

I know that every interested member of the Woman's Auxiliary will serve faithfully to accomplish our aims for it is strength in numbers which can shape the future of our country. This has been a war to bring understanding and tolerance and it is necessary that we on the home front keep our shoulders to the wheel.

I hope you all enjoy your vacations and return with new enthusiasm to increase our membership and build a stronger, more united Auxiliary.

## AUXILIARY REPORT

### Mercer County

Mrs. C. Chester Chianese, Publicity Chairman

Members of the *Woman's Auxiliary to the Mercer County Medical Society* met at the Medical Executive Offices in Trenton to assist the Society in its program to combat "Political Medicine". Auxiliary members were requested to donate some time to the work of preparing for mailing to each New Jersey physician the publicity material for which the Auxiliary was to receive an honorarium.

Two hundred hours were given by the following members from April 16th to May 4th, 1945: Mrs. F. M. Arthur, Mrs. Robert Applestein, Mrs. Joseph R. Burns, Mrs. J. J. Belfer, Mrs. Robert J. Cottone, Mrs. C. Chester Chianese, Mrs. H. Donald Cowlbeck, Mrs. Charles C. Cohan, Mrs. Harold Carson, Mrs. Alton S. Fell, Mrs. A. Guglielmielli, Mrs. A. Dunbar Hutchinson, Mrs. Joseph S. Kondor, Mrs. John Mras, Mrs. Frank A. McGulgan, Mrs. Harold Magee, Mrs. James J. McGuire, Mrs. Joseph Pantaleon, Mrs. H. Norton Parker, Mrs. Ernest F. Purcell, Mrs. Joseph Ragany, Mrs. George N. J. Sommer, Mrs. J. M. Schildkraut, Mrs. LeRoy A. Wilkes, Mrs. Wilbur Watts, Mrs. D. M. Yazujian.

The project was carried to a successful completion.

On May 9th, Auxiliary members who participated in this work were entertained by Dr. Joseph F. Londrigan, President of The Medical Society of New Jersey, at luncheon at the Trenton Country Club. Dr. Londrigan praised the Auxiliary for the interest and coöperation shown, and urged members to answer the call of their Society at all times. He also spoke on the state-wide Health Program during June which will be sponsored by The Medical Society of New Jersey.

Mrs. H. Donald Cowlbeck, President of the Mercer County Medical Auxiliary, accepted most graciously in behalf of the Auxiliary, the honorarium from Dr. Londrigan.

# BOOK REVIEWS

**Psychology of Women:** A Psychoanalytic Interpretation. By Helene Deutsch, M.D. Foreword by Stanley Cobb, M.D. v. 1. Pp. 399. 1944. $4.50.

At a time when the increasing waywardness among girls and the post-war readjustments which women must face are engaging the attention of those concerned with such problems, Dr. Deutsch's book is of special interest. In it she paints a clear and vivid picture of the development of woman's psychologic life, stressing the fact that emotional disturbances and neuroses in later life may be the result of earlier reactions in the young girl's life.

The early part of the book deals with the development of the psychologic life of the young girl and case histories of what are termed "the traumatic liabilities of puberty" have been included. These are what may be called the more spectacular types. It would have been interesting to have had instances of the opposite type of such "liabilities" such as the girl who, unusually shy and reserved in all her contacts, absorbs knowledge which is incomprehensible to her and so suffers both a conscious and an unconscious shock. If such a girl is one of the so-called "surprise" cases—and one grants that they are rare particularly in the present generation although it is believed that they do exist—she suffers a still further shock and if, later, other psychologic shocks are received the cumulative effect of these experiences may have a profound and lasting influence.

These girls do not usually find their way into the juvenile courts and perhaps such women do not often find their way into the physician's office. They seek to escape by denying their emotions and find refuge perhaps in purely intellectual pursuits, building a wall behind which they attempt to hide their emotions. They may achieve a certain measure of success but never the complete success and fulfillment which might have been theirs had they not been continually handicapped by fears they could not understand or overcome and torn by inner conflicts which they could not resolve.

In the latter part of the book Dr. Deutsch discusses three types of feminine personalities and traces the large part which emotion plays in a woman's life. It is made evident that in dealing with the emotional problems of women one must consider not only the immediate causes, but also the possibility of earlier reactions which have perhaps laid their foundation.

Dr. Deutsch has shown a keen insight and understanding of the behavior and emotional reactions of women. Her book has been read with much interest and it is believed that the information which it contains will be of much value to those who are called upon, in whatever capacity, to deal with girls and women.

GRACE SIMS, Social Investigator.
Essex County Welfare Board.

**Textbook of Ophthalmology.** By Sanford R. Gifford, M.A., M.D., F.A.C.S. 3d ed. Pp. 457. Philadelphia, W. B. Saunders Co. 1945. $4.00.

In a single volume of "manual" size, this book includes all the common and many of the less common ophthalmological conditions and discusses them in clear, concise fashion. The presentation is greatly aided by the large number of illustrations, which average one for each two pages of text, and by several fine color plates.

The recommended doses of certain therapeutic agents may be questioned. A subconjunctival injection of two minims of 2 per cent atropine (1/25 grain), for example, might well cause unpleasant, if not dangerous, reactions, as might typhoid vaccine given in the recommended minimum dose of 30 million organisms by vein.

It is unfortunate that in a book published in 1945 there is included the 1925 method of the American Medical Association for "Appraisal of Loss of Visual Efficiency" for compensation for eye injuries rather than the revised one of 1941. This is a matter of little importance and does not impair the general excellence of the book as a manual for students and general practitioners.

A. RUSSELL SHERMAN, M.D.

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**Dietotherapy:** Clinical Application of Modern Nutrition. Edited by Michael G. Wohl, M.D., with a foreword by Russell M. Wilder, M.D., Ph.D. Pp. 1029 with 93 illustrations. Philadelphia & London, W. B. Saunders Company. 1945. $10.00.

Material from the various fields of nutrition are authoritatively compiled in this book. Dr. Wohl has gathered around him outstanding authorities who have contributed the results of their many years of experience in this subject.

The contents of the book are divided into normal nutrition, nutrition in periods of physiological stress, and nutrition in disease. Each one of these parts is thoroughly covered with invaluable information. Every page is important, every paragraph is enlightening, and every sentence is informative.

Some of the topics discussed are: The normal diet; water metabolism; trace elements in nutrition and tracer substances; the vitamins in health and disease and nutrition in the various diseases; and finally, the amino acids as protein nourishment.

Many illustrations and charts are shown to simplify the text. The bibliographies are up to date and contain the best material published in nutrition.

This book should be part of the equipment of every doctor's office. It will probably be referred to more than any other book in the medical library.

S. WILLIAM KALB, M.D.

# Tuberculosis Abstracts

*A Review for Physicians*

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

**Vol. XVIII** **August, 1945** **No. 8**

WHENEVER an individual handicapped by arrested tuberculosis seeks employment, the private physician finds himself called upon to step into the role of referee. Only he can make the decision as to what will serve the best interests of the patient as well as protect the community and satisfy the requirements of industry. The medical adviser's success in discharging this key responsibility will depend largely upon close coöperation with all others concerned.

## THE PRIVATE PRACTITIONER AND THE INDUSTRIAL PHYSICIAN

The transition period for the tuberculous patient from a status of carrying on light activity to becoming a self-sustaining wage earner is a period of trial and error depending upon developing immunity and the results of two warring processes. Opposing one another are the tendency of the tuberculous infection to progress and the tendency of healing to occur. Unless it is appreciated that this period is a dynamic interval, the need for repeated check-ups may be overlooked.

In the minds of both the private practitioner and the industrial physician the welfare of the patient must be the primary issue, taking second place to no other consideration. Too often the patient feels that the primary objective is to earn a living. Occasionally he will not realize that check-ups are worth his time and his money, and, unfortunately, but quite infrequently, the family physician may feel similarly. More often, the patient is interested in: first, getting well; secondly, making a living; and thirdly, becoming a wage earner in a way that recovers his self-confidence, his respect for himself, and his position as a working, economic, and social constituent of his community. Of great importance is the indoctrination of the individual that check-ups are not to be feared. The patient must assume an aggressive and participating attitude in the fight against his disease.

The objective of the private practitioner is to fulfill the duties of his profession in getting the patient well. The physician has another interest, and that is to demonstrate the value of the private practice of medicine. This also has a financial aspect to the physician. The fight against tuberculosis cannot be won without the participation of the private practitioner of medicine.

The industrial physician on his part has at least three objectives: (1) The protection of all employees against open cases of tuberculosis; (2) the protection of the so-called arrested tuberculous patient from his own over-activity or poor judgment; and (3) the protection of the industry itself from financial loss in attempting to convert the tuberculous patient into a wage earner.

All are well aware of the validity of the first two points. The last point becomes significant when one hears that by some courts "aggravation of tuberculosis" is held compensable.

With due respect to the interests of the three parties mentioned above, what is to be accepted as evidence that a tuberculous patient is employable? (1) First and foremost is a series of X-rays demonstrating that the lesion is static or regressing under the conditions of living undergone by the patient during that period of observation. (2) It is essential that this period of observation covered by the serial X-rays include eight hours at least of daily activity, even though of light or moderate degree. (3) There must be an adequate series of negative sputum examinations. The author personally prefers a minimum of three consecutive negative sputum examinations, or, preferably, gastric aspirations. (4) An obvious increase in the feeling of well-being of the patient, such as complete absence of symptoms and a satisfactory weight history, is important. (5) A blood sedimentation rate has been found to be worth while,

and hence at least one normal blood sedimentation rate should be insisted upon. (6) A daily record of the temperature at 4:00 p. m. and 8:00 p. m. for an immediate period of ten days should be established. (7) There must be developed in the patient a proper attitude toward his own condition and a proper understanding of just what this trial-and-error period means in the way of mutual coöperation. By *proper,* "humble" or one of forfeiture of any rights is not meant. What is meant is good insight and a paramount will to get well. (8) Finally, there must be an available job which the applicant can do and may do without causing real or alleged damage to himself, or creating a menace to his fellow employee.

In order to achieve this, there must be a system of restricted placement, and, in setting up such a system the medical status of the individual must be kept confidential so that the employee will feel reassured, and thus be helped to establish self-respect and regain confidence in himself.

No classification system can be followed blindly. Individual evaluation of each case is necessary and any preformulated procedure of restricted placement is nothing more than an over-all guide. Such a restricted placement procedure must be revised constantly and kept up to date, and the health status of the individual must also be re-evaluated at regular intervals.

In connection with this re-evaluation, it may be worth while to discuss the author's manner of handling any one particular case. Whenever the routine pre-employment X-ray brings to light a lesion about which there is any question of activity, the applicant is refused employment until a thorough survey by his family physician or qualified agency is made available. Routinely, the author asks for: (1) previous chest X-ray record, if any; (2) at least three negative sputum examinations and, where warranted, at least one negative gastric aspiration; (3) a ten-day, twice a day, temperature record; (4) the sedimentation rate; (5) written permission of the physician caring for the case that this person may work; (6) following this evaluation, another discussion with the patient exploring and improving his mental attitude; and, lastly, a re-classification, taking into consideration other restricting disabilities the employee may have.

Depending upon the indications of this re-evaluation, the employee is reviewed in one, two or three months, and, according to the indications, these re-evaluations are either increased or decreased in time frequency throughout the year or years. This procedure applies to the white-collar men as well as the group that wears overalls.

Should a tuberculous patient with seniority displace, or "bump off," as they call it, another employee with less seniority on a job where there is a possible hazard for a tuberculous patient, a difficult problem might arise. Such a situation will demand that, above all other considerations, the health of the convalescent or "arrested" tuberculous patient be in no way endangered by compromise. If one realizes and practices the principles of health preservation with absolutely no compromise, this "bumping-off" problem will certainly be settled in a medically satisfactory manner.

An important phase of this problem will have been omitted if attention is not called to the need of financial aid to replace lost income for those individuals who must cease working for a period of time. Group health insurance is one such source of aid. Community welfare agencies and possibly federal agencies also may be able to help make up for this lost income.

*Coöperative Efforts of the Industrial Physician and the Private Practitioner in Re-employment of Arrested Tuberculosis Patients, J. F. Johnson, M.D., Industrial Medicine, January, 1945.*

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*Communications:* Members are invited to submit to *The Journal* any suggestions for the welfare of the Society, as well as comments or criticisms of any material in *The Journal*. All such communications should be directed to the Editorial Office of *The Journal*. The Publication Committee reserves the right to publish, reject, edit or abbreviate any communications submitted to it.

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**THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY**

**Editorial Office, 315 West State Street, Trenton 8, New Jersey**

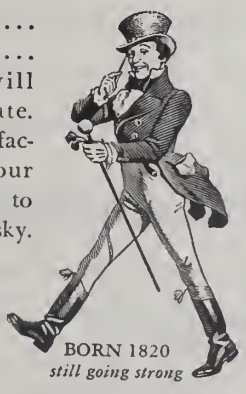


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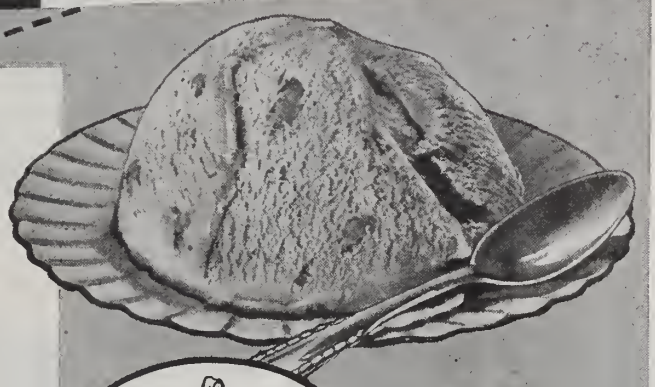
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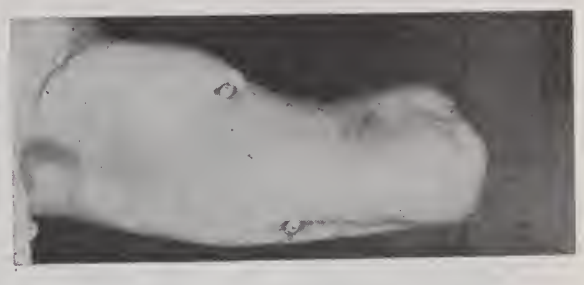
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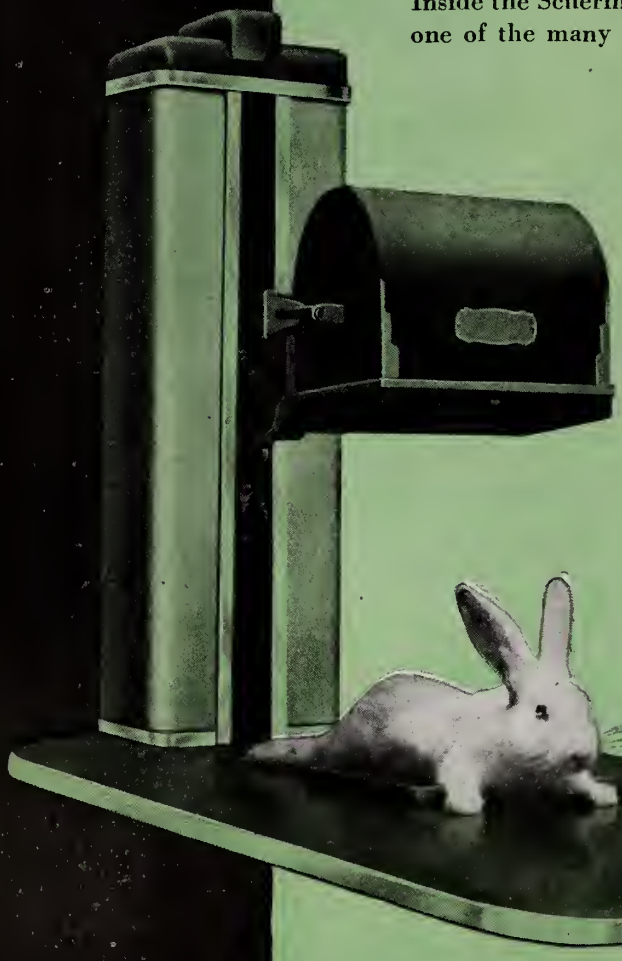
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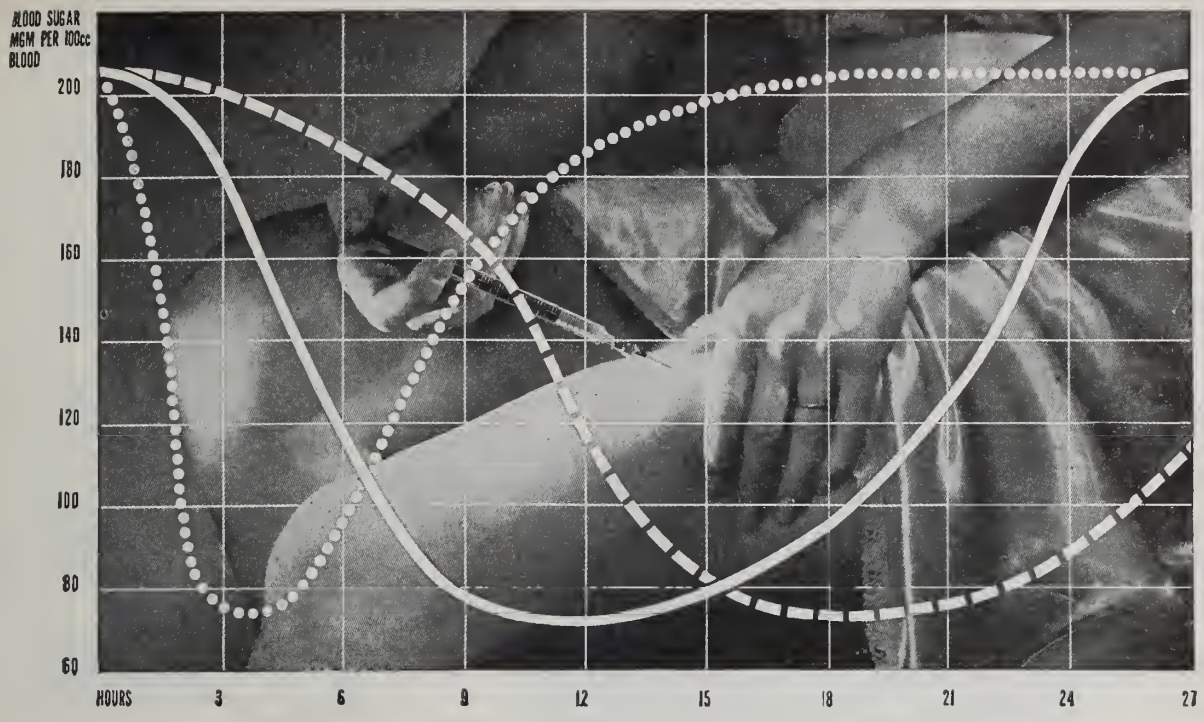
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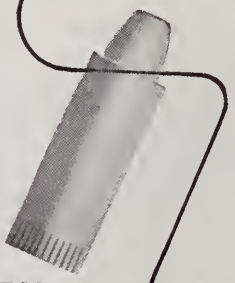
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The well nourished baby is more resistant to the common ills of infancy. Moreover it is during that all-important first year of life that the very foundation of *future* health and ruggedness is laid. Similac-fed infants are notably well nourished; for Similac provides breast milk proportions of fat, protein, carbohydrate and minerals, in forms that are physically and metabolically suited to the infant's requirements. Similac dependably nourishes the bottle fed infant *—from birth until weaning.*

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A powdered, modified milk product especially prepared for infant feeding, made from tuberculin tested cow's milk (casein modified) from which part of the butter fat is removed and to which has been added lactose, olive oil, cocoanut oil, corn oil and fish liver oil concentrate.

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# V-Day for the Doctor!



● "Good-bye, Doc—and thanks for everything!"

Yes, that's V-Day for the service doctor . . . victory in his war to *save* lives.

And doctor that he is—soldier too—he well knows how much a "smoke" can mean to a fighting man. He himself may find that same comfort and cheer in a few moments with a good cigarette. Very likely it's a Camel—for Camels are such a big favorite with fighting men—in O.D., in blue, and in *white*.




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Unsettled times like these bring the overburdened physician more than the normal number of patients suffering from chronic disorders of a cardiac, vascular or rheumatic nature.

Here at the Spa, in superb plant facilities placed in a restful setting of great natural beauty, your patient will find the restorative care he needs to prepare him for the full benefit of your continued medical direction.

Under regimens of treatment which you yourself recommend, your patient, relaxed in mind and body, draws a full measure of improved health from the Spa's naturally carbonated mineral waters.

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# THE SARATOGA SPA

**"PHYSICIAN, GIVE HEED TO THINE OWN HEALTH"**

Many physicians have recently come to the Spa for the same kind of treatments that helped their patients here. After a restorative "cure" at the Spa, you, too, would return to your practice refreshed—revitalized—ready for the busy days that still lie ahead.

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# Medications of Choice FOR THE SPECIFIC INVOLVEMENT



## Auralgan

**in ACUTE OTITIS MEDIA**

*Symptoms*

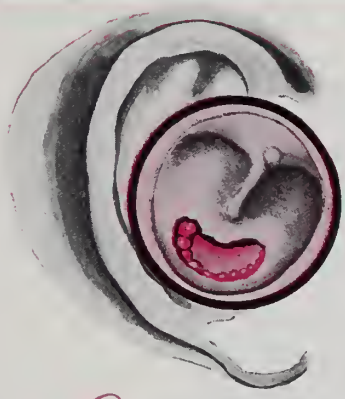
Pain, fever, edema, leucocytosis, sense of fullness and impaired hearing.

*Treatment*

Relief of pain and inflammation—Auralgan.

*Action*

Decongestant, analgesic, bacteriostatic.



## Otosmosan

**in CHRONIC SUPPURATIVE OTITIS MEDIA**

*Symptoms*

Persistent discharge, often foul smelling, usually no toxemia, no pain, no fever.

*Treatment*

Otosmosan.

*Formula*

Sulfathiazole carbamide 20% in glycerol (Doho).

*Action*

Deodorizes the discharge, liquifies unhealthy granulations, bacteriostatic, permits normal epithelialization.

Scientific data and reprints of clinical studies reporting upon the use of Otosmosan available on request.

*Complimentary quantities for clinical trial*

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Patient of intermediate type-of-build (skeleton indrawn)

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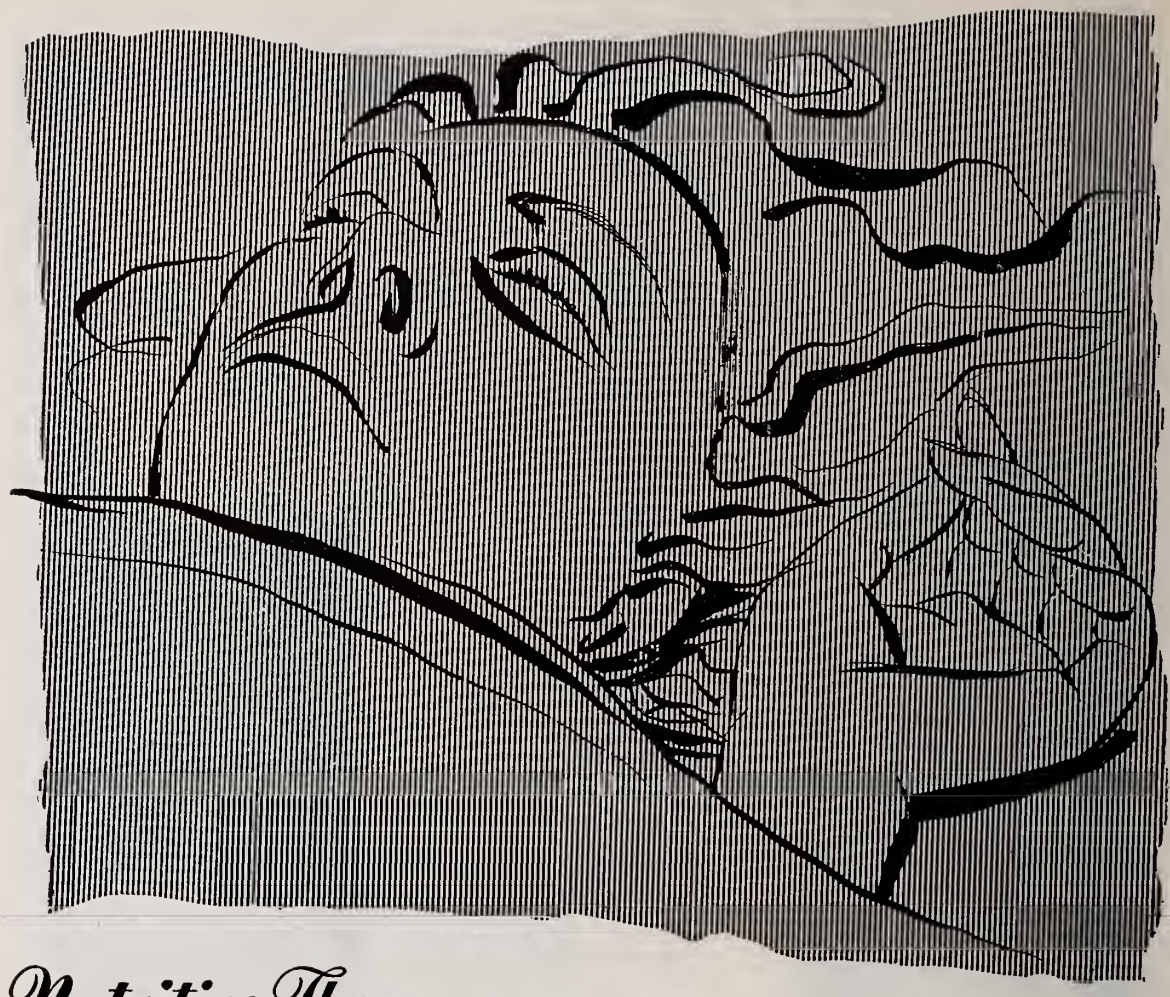
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When the nutritive status of any patient is severely impaired, supportive therapy centers about four essential measures[1].

1. High caloric, high protein diet, within the tolerance of the patient.
2. Prompt administration of thiamine, riboflavin, niacinamide and ascorbic acid *in dosage which clinical experience[1,2] has shown to be effective.*
3. The natural B complex[1] in adequate dosage.
4. Additional administration of vitamins[2], calcium, and iron, if and as indicated.

Specific vitamin deficiencies, excepting in the case of vitamins D and K, are usually symptomatic of generalized nutritive failure. Many seeming contradictions in the literature become clear when this is understood. Use of the specific vitamins alone is at best symptomatic treatment and will not restore the patient to full health.

For further information write to Squibb Professional Service Dept., 745 Fifth Ave., New York 22, N. Y.

(1). Spies, Tom D.; Cogswell, Robert C., and Vilter, Carl: J.A.M.A. (Nov. 18) 1944. Spies, Tom D.: Med. Clin. N. Am. 27:273, 1943. (2). Jolliffe, Norman, and Smith, James J.: Med. Clin. N. Am. 27:567 (March) 1943.

**SQUIBB** *Nutritive Agents*

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Herwick, Welch, Putnam and Gamboa* offer two important conclusions regarding the possibility of irritation after intramuscular injection of penicillin. They are that:

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*J.A.M.A. 127:74-76 (Jan. 13) 1945.

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This pleasant-to-take preparation enables infants, squeamish children, and fastidious adults to receive generous amounts of 6 vitamins—A, $B_1$, $B_2$, C, D, and niacinamide—in a convenient manner. 15-cc vials and 60-cc packages . . . . HOFFMANN-LA ROCHE, INC., Roche Park, Nutley 10, N. J.

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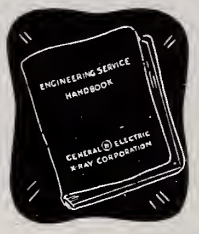
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Originated as a non-irritating, non-lathering replacement for soap in various skin disorders, Acidolate also successfully solved the problem of removing residual ointments, creams and oils from the hair, scalp and glabrous skin, because it:

1. Emulsifies ointments and other fatty materials almost immediately on addition of water. Low surface tension brings this concentrated yet bland detergent into intimate contact with the superfluous matter and permits deep penetration of skin crevices.
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4. Prepares the skin for further therapy by also removing secretions and debris.
5. Conserves time and effort for the patient, nurse and physician.
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ACIDOLATE is a sulfated-oil preparation with an extensive background of clinical research. It is water miscible, non-abrasive, hypo-allergenic, and has an acidity (pH 6.25) approximating that of non-pathologic skin.

*Directions:* Pour small amount of Acidolate directly onto area to be cleansed. Effect dispersion by means of gentle massage, using a cotton pledget or gauze pad if desired. Rinse with water or physiologic salt solution, preferably warm. Repeat if necessary.

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Take cigarettes for example.

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**Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154*
*Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60*
*Proc. Soc. Exp. Biol. and Med., 1934, 32, 241*
*N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592.*

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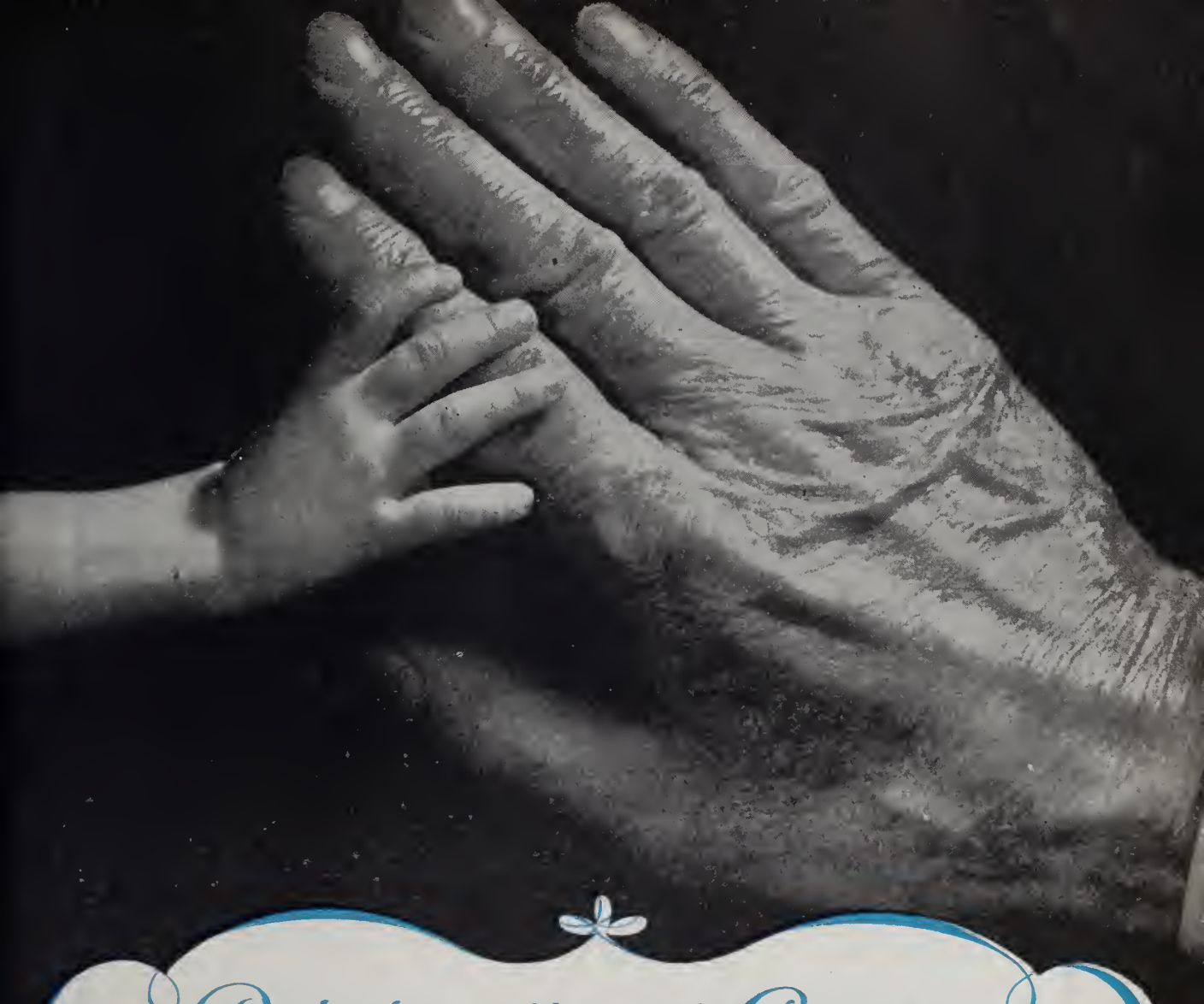
Among man's protein foods meat ranks high, not only because of the percentage of protein contained, but principally because its protein is of highest biologic quality, applicable wherever protein is required.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

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Therefore, urge parents to have their child's eyes examined immediately.

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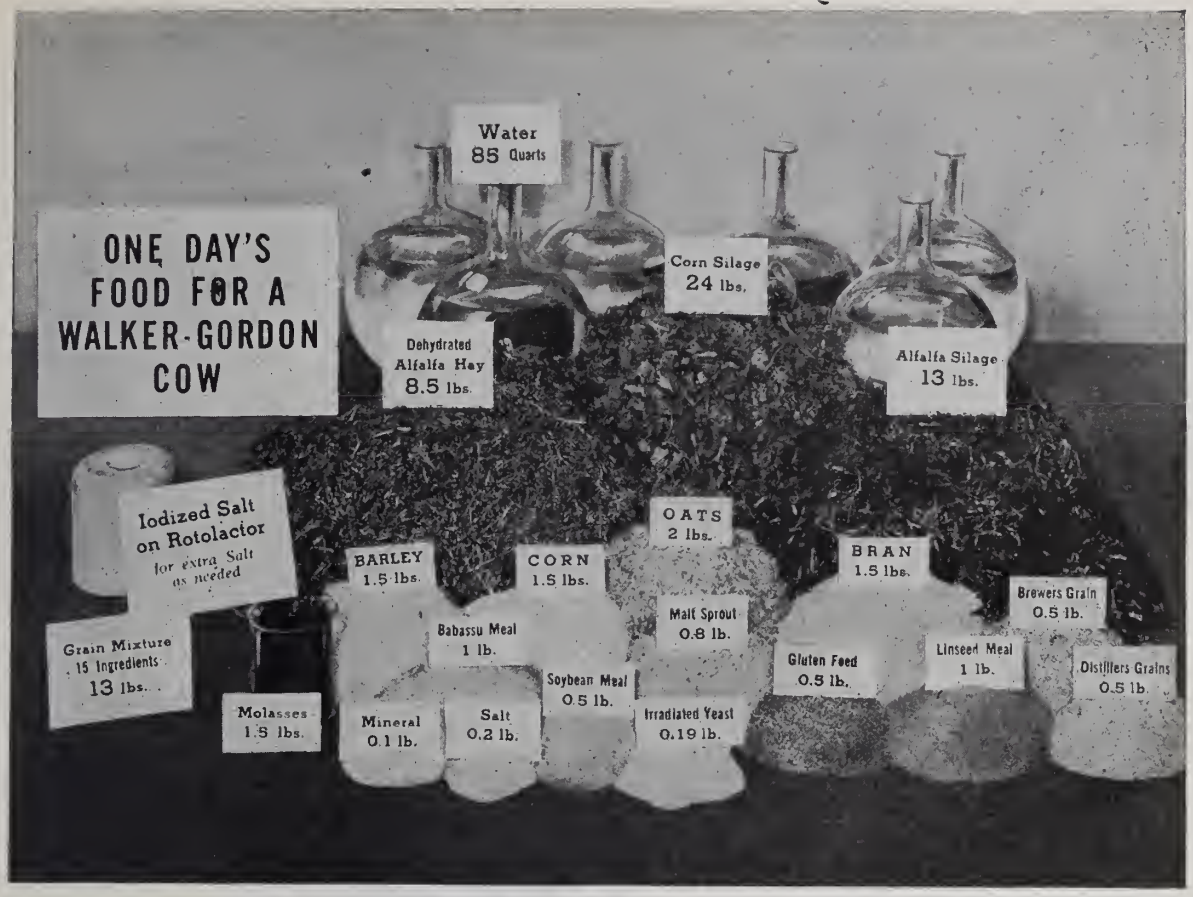
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# How many cows get a scientific ration like this?

THIS SCIENTIFIC daily ration was developed after years of study by the Walker-Gordon Laboratories.

It's remarkably rich in vitamins and health-giving minerals . . . And that's *one* big reason why Walker-Gordon cows produce a milk far superior to the type you get from cows that are fed in the ordinary, unscientific way.

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***The World's Finest Milk***




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"His condition requires careful dietary supervision – with Dryco you can easily adjust the formula to meet his requirements."

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DRYCO *is made from spray-dried, pasteurized, superior quality whole milk and skim milk. Provides 2500 U.S.P. units vitamin A and 400 U.S.P. units vitamin D per reconstituted quart. Supplies 31½ calories per tablespoon. Available at all drug stores in 1 and 2½ lb. cans.*

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THE "CUSTOM FORMULA"
INFANT FOOD




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WHEN the physician reaches a decision that conception would present an undue hazard to health, the "RAMSES"* Flexible Cushioned Diaphragm may be prescribed with confidence. The unique patented construction of the rim provides a wide unindented area of contact with the vaginal walls, plus a buffer against spring pressure.

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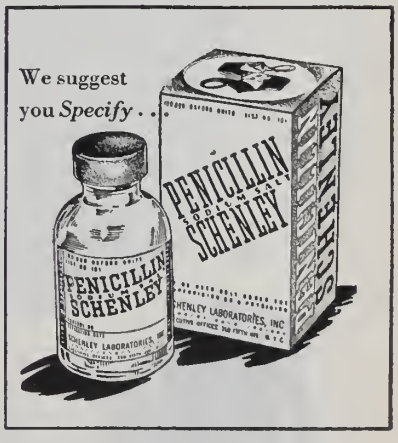


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The penicillin which first attracted the attention of Alexander Fleming was an "occurrence of nature", with no control exercised over the conditions of its production. Production of pyrogen-free penicillin for the medical profession, however, is accomplished only by the most elaborate methods of control for insuring highest attainable productivity, potency, and purity.

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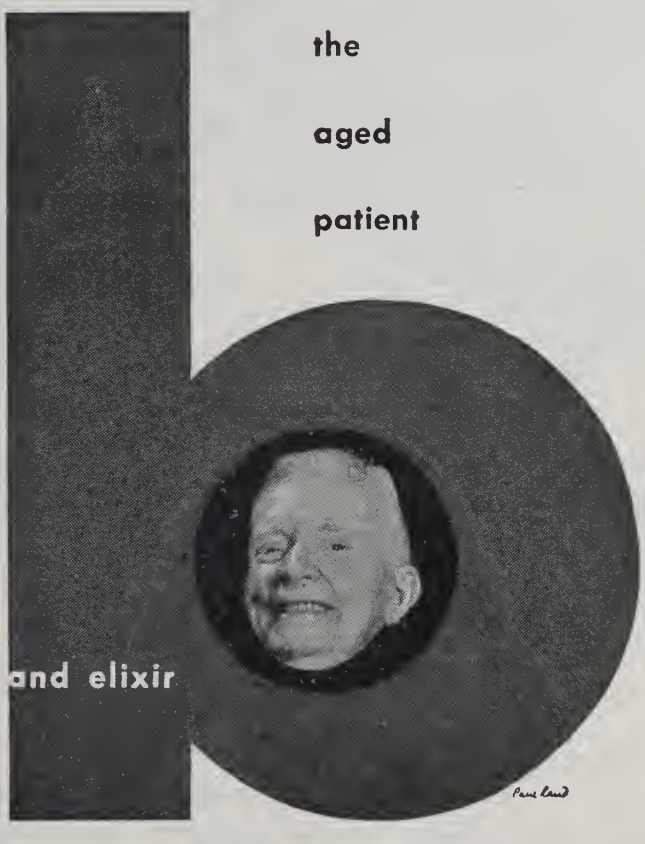


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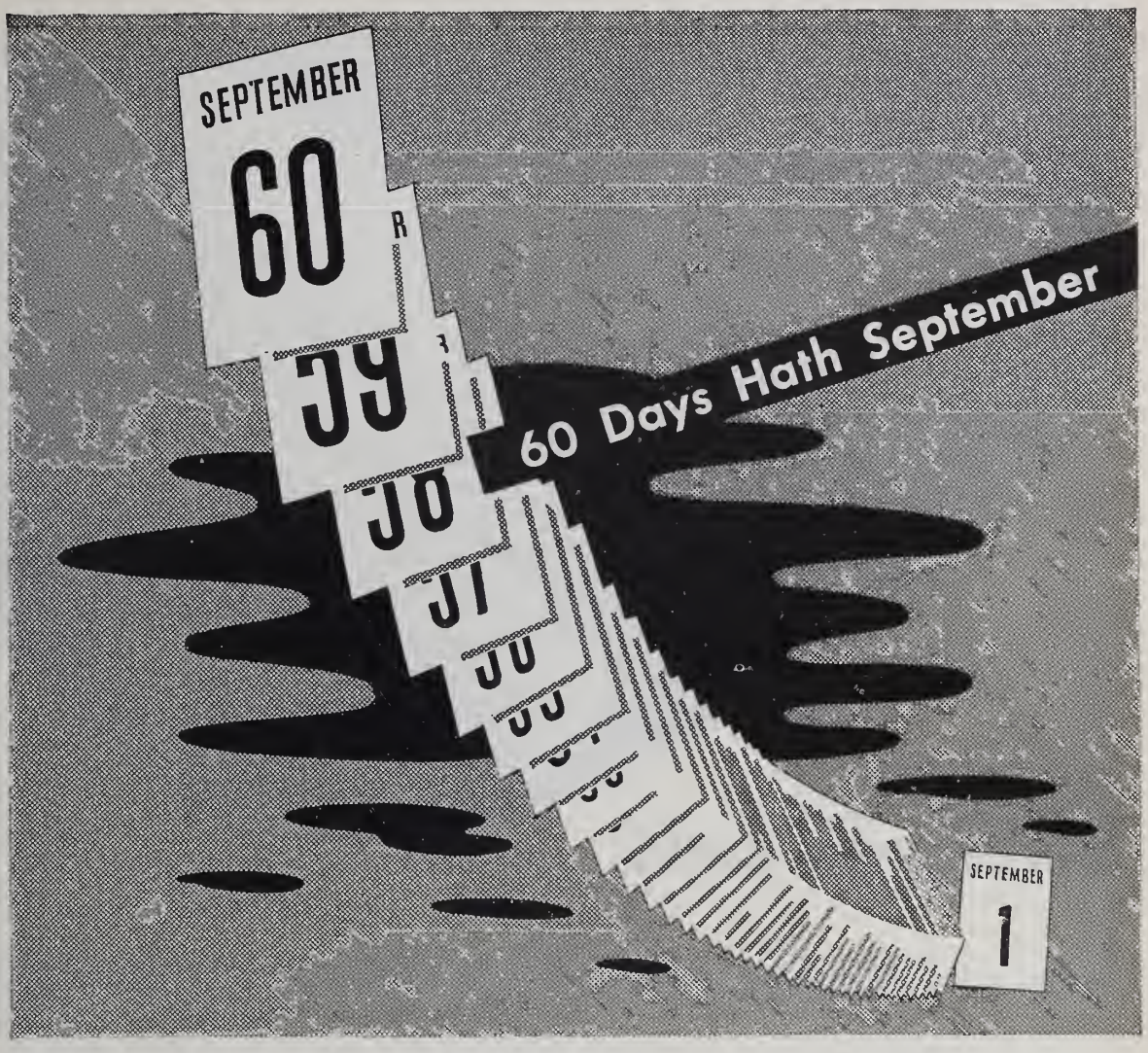
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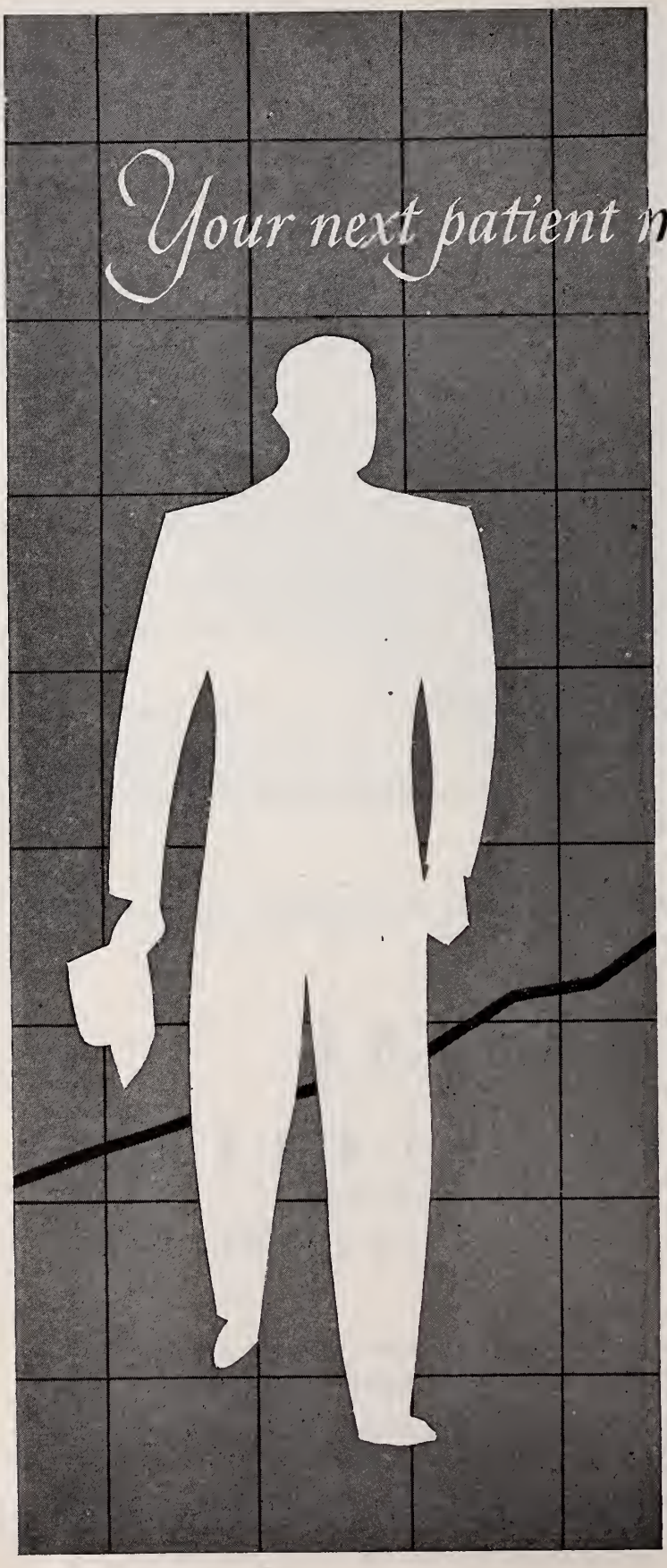
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*Blotner, H., and Hyde, R. W.: New England J. Med., 229:885, 1943.

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# EDITORIALS

## DISCHARGE OF MEDICAL OFFICERS

The Army has announced that medical officers will be released from active duty in accordance with a point system. The plan establishes two classes of officers; one, composed of scarce specialists for whose services a great need exists in the army, and the other composed of less scarce specialists and general duty officers. A definite point score has been established for each group.

The plan, as published on August 5th, states, "These criteria, therefore, create no vested right in any officer to discharge, but constitute the goal to be sought, and the general rules to be applied in the absence of supervening military necessity."

1. "Medical Corps officers returned by a theatre or declared surplus by a major force (except those with primary military occupation specialties listed in paragraph below) are eligible for relief from active military duty if their adjusted service rating is 100 or more.

2. "Medical Corps officers in certain scarce military occupational specialties are eligible for relief from active military duty if they have an adjusted service rating of 120 or more:

"Gastro-enterology
Ophthalmology and Otorhinolaryngology
Cardiology
Dermatology
Allergies
Anesthesia
Neuropsychiatry
Neurosurgery
Thoracic Surgery
Plastic Surgery
Orthopedic Surgery
Clinical Laboratory

3. "Medical Corps officers over 50 years of age, irrespective of their specialty classification, are eligible for relief from active military duty if they are returned to the United States by a theater or declared surplus by a major force.

4. "No Medical Corps officer with an efficiency index of 41 or more who desires to remain on active military duty will be relieved, irrespective of age, military occupational specialty or adjusted service rating."

The point system, or adjusted service rating, is as follows:

| | |
|---|---|
| 1. Each month of active duty | 1 point |
| 2. Each month of foreign duty an additional | 1 point |
| 3. Each battle campaign | 5 points |
| 4. Each decoration | 5 points |
| 5. Each dependent child under 18 years of age on V-E Day | 12 points |

The point system as outlined above is obviously unfair to two classes of officers: (1) those who through no fault of their own served their entire period of active duty within the continental limits of the United States, and (2) those older officers whose children had passed their 18th birthday on V-E Day. The Surgeon General's office recognized this defect and is studying possible amendments to the plan to meet the situation.

The surrender of Japan will liberalize the plan. Less officers will be needed for Pacific duty than contemplated under the original plan. But, our military hospitals are now at their high peak of bed occupancy, with a total of about 500,000 patients who must remain under army jurisdiction until ready for discharge or until other arrangements are made to provide maximum hospital benefit.

Since the discharge of medical officers will be accomplished automatically under the plan there will be no particular function in the program for Procurement and Assignment Service. The Directing Board of Procurement and Assignment Service will meet on August 25th to determine its future obligations and the future functions of this service. It is now contemplated that the New Jersey Procurement and Assignment Service will play no part in the program except in an advisory capacity regarding the return of specific officers to meet the needs of communities with a physician-population ratio of less than one physician to 3,000 population, and the arranging for the deferment of commissioned internes to serve as residents in our hospitals.

This report is purely factual. Under present conditions, and so soon after the actual signing of the Japanese Peace Treaty, with the army spread over the entire globe we cannot express too much optimism regarding the early return of medical officers to our communities. It is a big administrative problem; first the officers must be returned to this country before discharge can be accomplished. Allowances must be made to care for the occupational forces in Europe and in the Orient. The discharge of medical officers cannot be accomplished at a rate faster than the discharge rate in the army as a whole, and finally certain highly trained personnel must be retained by the army to care for the tremendous load of wounded men now occupying beds in army hospitals, until arrangements for their adequate care can be made with other agencies. This, however, should be accomplished within the next few months and we may look forward to a solution of our community problems by the discharge of officers on the point system as arranged by the Surgeon General of the Army.

## MEDICAL CARE OF THE VETERAN

Recently we have been receiving frequent requests from physicians regarding the proposed plan of the Veterans Bureau providing for the care of veterans by civilian physicians.

The Veterans Bureau has recently been placed under the administrative control of Major General Omar Bradley. Major General Paul Hawley, M.C., U.S.A., has been appointed Medical Adviser to General Bradley. He will be assisted by Brigadier General Elliott Cutler, M.C., A.U.S., Professor of Surgery at Harvard Medical School. These new officers have not been on the job long enough to express an opinion or make recommendations as to the final arrangement, but do give assurance that a Plan will be evolved under which the care of service-connected disabilities will be available to veterans from physicians of their home communities. The program therefore is at present in a state of flux.

Steps have already been taken to evolve such a Plan in New Jersey. The following statement regarding the Plan in New Jersey is published following its review by the Regional Office of the Veterans Bureau at Lyons, New Jersey.

"In view of the rapid expansion of Veterans Facilities, and in order that veterans may obtain medical care in their home communities, the United States Veterans Administration is developing a program whereby veterans may receive medical care by civilian physicians in their home communities for service-connected disabilities.

"Eligible services will include services rendered in the office of the physician, home of the patient and in civilian hospitals.

"Non-service-connected disabilities are not included in the program, such disabilities being eligible for treatment only to veterans admitted to a Veterans Administration Facility. An exception to this is the case of female veterans in whose care both service-connected and non-service-connected disabilities will be eligible for treatment by civilian physicians in civilian hospitals. The program will not include obstetrical care or the care of dependents.

"Participating Physicians, known as 'Designated Physicians', and coöperating hospitals, are now being enrolled through the office of the Chief Medical Officer, Major R. C. Fagley, at the Veterans Facility, Lyons, New Jersey.

"Payment for services will be in accordance with the Veterans Administration Fee Schedule, now being amended with the advice of individual physicians and specialty groups, or on a per annum salary basis at a rate having the same relation to a full-time salary of $4300 per year as the time worked has to a 40-hour week. Salary for a part-time Specialist will be higher.

"Headquarters of the program will be established in Newark. Branch Offices and clinics will be established in Camden, Trenton, Paterson and Atlantic City. The personnel of the branch offices will consist of full-time Veterans Administration physicians, dentists, nurses, and social service workers, supplemented as necessary by part-time civilian physicians.

"The veteran will establish his claim for services at a branch office, or at the Newark Regional Office. His claim will be passed upon by a Rating Board of the Administration, and if approved, the veteran will be referred to a Designated Physician in or near his home community for treatment."

## MEDICAL-SURGICAL PLAN OF NEW JERSEY

The following quotation is a letter received from an organization which pays part of the cost of Medical-Surgical Plan for its employees. This organization is thus backing the efforts of organized medicine to maintain the private practice of medicine as a private enterprise. All they expect in return is that the members of the profession carry out the contract of the Plan, as sponsored by The Medical Society of New Jersey. The matter under discussion involves the very integrity of the profession upon which the successful solution of the medical care distribution problem must depend.

Similar complaints are occasionally received but on the whole our Participating Physicians are carrying out the provisions of our contract to the last letter, thus creating in our minds a sense of assurance that a solution of this problem can be evolved by the profession itself:

"A number of our employees have reported difficulties with their individual doctors who are listed as coöperating doctors.

"In some cases employees have been advised that the doctor was not a member of the plan, although his name was included in your list. The writer has had occasion to communicate with these doctors, or their offices, and finally obtained admission that they actually were enrolled in the Plan as coöperating doctors. In some cases even the office nurse denied that her employer was in the plan, although his name was included in your list.

"Our employees have also had difficulties when it came to settlement of charges made by their doctors. Quite a few of these doctors claimed to have no knowledge whatever of your procedure as regards their remuneration. They insisted that the bill should be rendered to the patient. Again, the writer has communicated with some of these doctors and tried to explain to them that they were supposed to send their bill to you for patients who were members of the Plan and that you in turn would settle with them.

"The writer hesitates to make any suggestions as to what you should do, but there appears to be a definite need for a campaign by you toward educating the coöperating doctors and particularly their office nurses as to the correct procedure to be followed in the cases where patients are members of your plan.

"This suggestion is made, not in a spirit of criticism, but in the conviction that its adoption would largely reduce the amount of detail work."

### ENROLLMENT

As of July 31st a total of 45,859 persons were enrolled under effective contracts with an additional 1580 persons enrolled under contracts becoming effective in August for a grand total of 47,439 persons enrolled under 21,029 contracts.

### EXPERIENCE OF PLAN DURING FIRST SEVEN MONTHS OF 1945

| Earned Subscription Income | Claims Paid and Accrued | Per Cent of Income | Operating Costs | Per Cent of Income |
|---|---|---|---|---|
| $172,462.66 | $114,673.61 | 66.5 | $30,401.96 | 17.6 |

### EXPERIENCE DURING MONTH OF JULY 1945

| Earned Subscription Income | Claims Accrued | Per Cent of Income | Operating Costs | Per Cent of Income |
|---|---|---|---|---|
| $ 29,514.00 | $ 20,562.50 | 70.6 | $ 5,096.41 | 17.2 |

## RESERVES

The total reserve accumulated during the seven months was $27,387.09, equal to 15.9 per cent of earned income. The Plan has no desire to accumulate large reserves and appreciates the fact that money held in reserve does not improve medical care distribution. It does indicate the financial stability of the Plan. Past experience has shown that more medical care is rendered during the last six months of the year than during the first six months and that reserves must be set aside early in the year to carry our additional claim load during the latter half of the year. Then there is the fact that we have not yet assumed our anticipated load of obstetrical cases. During the first seven months obstetrical cases constituted only eight per cent of admissions whereas we anticipate they will reach 20 per cent of admissions when our groups have completed their nine months' waiting period for obstetrical care.

## ADMINISTRATIVE PROCEDURE REGARDING CLAIMS

Physicians can assist us and help in reducing administrative costs by adhering to our routine in handling claims.

Each of our subscribers is also a subscriber to Hospital Service Plan of New Jersey. When a subscriber or enrolled dependent of Hospital Service Plan of New Jersey is discharged from the hospital a record of his admission is sent by the hospital to Hospital Service Plan of New Jersey. This record contains the name of the attending physician.

If the patient is also enrolled in Medical-Surgical Plan, we are furnished with copy of the report from the hospital through the facilities of Hospital Service Plan. We then send to the attending physician a copy of our "physician's statement" upon which to render his bill to this office.

If within a reasonable time a physician does not receive a "physician's statement" pertaining to a Plan patient, he should notify this office. The delay may be due to an administrative defect, but we would like to discourage the rendering of physicians' bills on the private billhead of the physician. Bills received in this manner are placed on our claim registry but cannot be paid until the report from the hospital is received.

The Plan distributes checks to physicians twice a month so that ordinarily a physician should receive payment of our benefit for eligible services within two weeks of the time his "physician's statement" is received in the office of the Plan.

## EXPERIENCE TO DATE

The Plan so far has had a successful experience. It is accomplishing the objective set for it by the Society. Our predetermined estimates as to incidence of service and cost to the Plan have proven to be reasonably correct. We are meeting the expressed need of persons of low income. The Plan, and similar plans being conducted by 20 other State Societies, represent the only bulwark so far established to protect the future welfare of the private practice of medicine. With the continued support of the profession we believe we can evolve a satisfactory alternative for compulsory sickness insurance, but to do so requires a demonstration of the sincerity and integrity of the individual physician in carrying out the provisions and intent of our contracts.

# ORIGINAL ARTICLES

## PRIMARY ATYPICAL PNEUMONIA: A STATISTICAL ANALYSIS

CAPTAIN WILLIAM A. TANSEY, M.C., A.U.S.
CAPTAIN PERRY J. CULVER, M.C., A.U.S.
MAJOR THOMAS F. FRIST, M.C., A.U.S.

### INTRODUCTION

In the past several years a number of papers have appeared in the literature concerning Primary Atypical Pneumonia. This disease has been variously designated "Bronchopneumonia of Undetermined Etiology", "Virus Pneumonia", "Pneumonitis", "Acute Bronchiolitis with Associated Bronchiectasis". The last mentioned designation is, perhaps, the most accurate from the pathological standpoint.

This paper is a preliminary report, covering an analysis of some 630 cases, and is presented for the purpose of guiding the general practitioner in the diagnosis and treatment of Primary Atypical Pneumonia. Further, it is our purpose to point out the absolute necessity for roentgen-ray examination in arriving at this diagnosis. When undiagnosed, the symptoms of this disease may trouble the patient for many months, whereas when the diagnosis is arrived at early in the course of the disease the proper amount of bed rest will often effect a complete cure in two or three weeks.

### MATERIAL

This is a review of all cases of uncomplicated Primary Atypical Pneumonia which were admitted on the Medical Service of an AAF Regional Hospital between 1 January 1942 and 15 August 1943. The total number of cases in this series is 630. Of this number, 200 cases were followed by the authors in great detail, and will be given special consideration. Omitted are all cases with complications, no matter how slight, and all cases in which there was some concurrent disease detaining the patient in the hospital.

The problems of epidemiology and etiology of the disease will not be discussed in this paper. Suffice to say that the etiology has not been established.

### ONSET OF DISEASE

The onset of this illness is almost always insidious. The patient usually feels that he is developing a common cold. In a great number of instances he will postpone his visit to Sick Call for many days. It is very probable that the disease may quite frequently be of such mild degree in some individuals that they will recover spontaneously without seeking medical advice.

Of the 200 cases that received special study, the following table indicates the approximate duration between onset of symptoms and admission to the hospital for the disease.

TABLE NO. 1
DURATION OF TIME FROM THE ONSET OF SYMPTOMS UNTIL HOSPITALIZATION

| Duration | Number of Patients |
|---|---|
| 0 to 2 days | 69 |
| 3 to 5 days | 40 |
| 6 to 8 days | 24 |
| 9 to 11 days | 8 |
| 12 to 14 days | 16 |
| 3 to 6 weeks | 35 |
| 7 weeks plus | 8 |

### PRESENTING SYMPTOMS

In Table No. 2 we have reviewed the presenting symptoms in the 200 case group. All 200 cases were investigated as to the presense or absence of each symptom noted in the left hand column. Note that cough is the only symptom that was present a sufficient number of times to be of real diagnostic value. The other symptoms were absent as often as they were present.

The chest pain was usually described as a substernal pressure or a "heaviness". Rarely was there severe pleuritic pain.

The characteristic type of sputum was yellow, tenacious, mucoid, and occasionally there were a few blood streaks. Never was the sputum prune-colored.

TABLE NO. 2

PRESENTING SYMPTOMS IN ORDER OF FREQUENCY

| Symptom | No Mention | None | Slight | Average | Severe | Per Cent of Cases in Which Inquiry Was Made and Symptoms Present |
|---|---|---|---|---|---|---|
| Cough | 11 | 14 | 49 | 84 | 42 | 92.5 |
| Headache | 65 | 61 | 15 | 51 | 8 | 54.8 |
| Sputum | 51 | 68 | 32 | 38 | 11 | 54.3 |
| Chills | 71 | 59 | 20 | 47 | 3 | 54.2 |
| Sore throat | 59 | 73 | 31 | 34 | 3 | 48.0 |
| Chest pain | 69 | 70 | 12 | 44 | 5 | 46.5 |
| Malaise | 74 | 69 | 9 | 45 | 3 | 45.2 |
| Coryza | 70 | 73 | 20 | 35 | 2 | 43.8 |

## FEVER

In Table No. 3 we have presented the highest temperature in the 200 cases observed by the authors, while the duration of fever for the entire 630 cases is shown in Table No. 4. Note that 6 per cent of the 200 case series and 9 per cent of the entire 630 cases had no fever. The mildness of the clinical symptoms could be correlated with lack of fever.

TABLE NO. 3

HIGHEST RECORDED TEMPERATURE IN 200 CASES

| Temperature | No. of Patients |
|---|---|
| To 98.6 | 12 |
| 98.8 to 99.8 | 21 |
| 100 to 100.8 | 22 |
| 101 to 101.8 | 46 |
| 102 to 102.8 | 42 |
| Above 103 | 57 |

TABLE NO. 4

DURATION OF FEVER IN THE ENTIRE SERIES OF 630 CASES

| Days | No. of Patients |
|---|---|
| 0 | 57 |
| 1 | 113 |
| 2 | 90 |
| 3 | 101 |
| 4 | 81 |
| 5 | 65 |
| 6 | 47 |
| 7 | 29 |
| 8 | 13 |
| 9 | 13 |
| 10 | 5 |
| 10-X | 20 |

The temperature of 75 per cent of the cases never rose above 103°. After the patients were put at absolute bed rest the fever promptly returned to normal. In 66 per cent of the cases it became 98.6° in four days or less. The fever in 97 per cent of the cases had reached normal levels before the end of ten days. In most of the cases where fever did not promptly return to normal, it was discovered that the patient was not adhering to the policy of strict bed rest and got up without permission.

## DURATION OF HOSPITAL STAY

The average duration in hospital days for the entire series of 630 cases as noted in Table No. 5 was 20.4 days. A similar average stay of 20.5 days was found in the 200 cases treated by the authors themselves. Considering the prevalence of this disease it is easy to see how the non-effective rate of a military command can be affected seriously.

The length of hospital stay was determined on the basis of serial roentgenograms. It was discovered from experience that if patients were permitted to resume physical activity and return to duty as soon as they became afebrile and felt well, which in most cases occurred within five to ten days after admission, there was prolonged asthenia sometimes lasting for several months, and often a recrudescence of the pneumonic process. After such results with the earlier cases in this series, a rule was made on an empirical basis that all cases of atypical pneumonia were to be kept on strict bed rest until x-rays, repeated at five-day intervals, showed complete or practically complete resolution. This rule was adhered to regardless of absence of clinical symptoms. Our clinical impression is that although the actual days of hospital stay were increased, the patients were able to return to strenuous military duty without the handicap of a prolonged post-infectious asthenic state.

TABLE NO. 5

Duration of Hospital Stay

| Days | No. of Patients |
|---|---|
| 5-10 | 51 |
| 11-15 | 152 |
| 16-20 | 185 |
| 21-25 | 100 |
| 26-30 | 62 |
| 31-35 | 41 |
| 36-40 | 14 |
| 41-45 | 9 |
| 46-60 | 11 |
| Longer (62 to 128 days) | 6 |

## ROENTGEN-RAY FINDINGS

The diagnosis of every case in this series was established on the basis of roentgen-ray findings. Characteristically the film showed a soft, fluffy infiltration (not unlike tuberculosis) radiating from the bronchial trunk. Occasionally there was homogeneous density of the entire lobe, or part thereof. Further, it was a common experience to have the initial x-ray reported as negative and upon repeating x-ray in 24 or 48 hours to find the typical infiltration of Primary Atypical Pneumonia.

The following table indicates the number of times each particular lobe of the lung was involved on x-ray for the total series of 630 cases.

TABLE NO. 6

Distribution of Lung Involvement by X-Ray

| Lobe of Lung | No. of Times Involved |
|---|---|
| RUL | 57 |
| RML | 7 |
| RLL | 282 |
| LUL | 30 |
| LLL | 338 |

Note that 86.8 per cent of all Primary Atypical Pneumonias occurred in the lower lobes. In 90 cases, or 14.5 per cent, there was involvement of more than one lobe in a particular patient.

In 94 cases of the 200 case series, the involved lobe was identified at the time of the admitting examination. In 90 cases, either the diagnosis was not correctly made, or the involved lobe was not identified. The remaining 16 cases are not considered in this respect for several reasons. For example, occasionally the patient was admitted from Sick Call with the x-ray diagnosis already appended to his chart.

These figures, therefore, present the startling fact that at the time of admission, even though the patient was thoroughly examined and the diagnosis well considered, there were insufficient physical signs to aid in the detection of the true diagnosis.

## PHYSICAL SIGNS

In the 94 cases in which the involved lobe was identified at the time of the admitting examination, the following physical signs were helpful, individually or in combination.

TABLE NO. 7

Physical Signs Noted on Admission

| Signs | No. of Patients |
|---|---|
| Suppression of breath sounds | 35 |
| Harsh, roughened breath sounds | 36 |
| Râles | 53 |

In many other instances the breath sounds were bizarre. Wheezing was often present. Further, breath sound changes often pointed to involvement of one lobe, whereas the x-ray subsequently showed the process to be on the other side. At some time during hospitalization every case showed râles and other transitory physical signs such as wheezing over the involved lobe. Often these signs did not appear until several days after the x-ray picture was positive. The physical signs of consolidation were conspicuous by their absence.

It must again be emphasized that if we are to arrive at the diagnosis of Primary Atypical Pneumonia with sufficient accuracy we must rely upon roentgenograms.

## WHITE BLOOD COUNT AND DIFFERENTIAL

The white blood count was found to be normal in the majority of the cases. By referring to Table No. 8 it can be seen that 89 per cent of the 630 cases had a white blood count between 4,000 and 10,000. Whenever the count was above 10,000, one began to suspect a secondary bacterial infection of the lungs or a bacterial infection elsewhere in the body.

TABLE NO. 8

DISTRIBUTION OF TOTAL WHITE BLOOD COUNT

| White Blood Count | No. of Patients |
|---|---|
| 2000 | 1 |
| 3000 | 16 |
| 4000 | 49 |
| 5000 | 54 |
| 6000 | 99 |
| 7000 | 105 |
| 8000 | 73 |
| 9000 | 57 |
| 10000 | 34 |
| 11000 | 24 |
| 12000 | 16 |
| 13000 | 12 |
| 14000 | 6 |
| 14000+ (Highest 25,400) | 20 |

TABLE NO. 9

DISTRIBUTION OF DIFFERENTIAL WHITE BLOOD COUNTS

| Neutrophiles | No. of Patients | Lymphocytes | No. of Patients |
|---|---|---|---|
| Below 40% | 6 | Below 10% | 24 |
| 41-45% | 6 | 11-15% | 58 |
| 46-50% | 35 | 16-20% | 107 |
| 51-55% | 25 | 21-25% | 101 |
| 56-60% | 67 | 26-30% | 107 |
| 61-65% | 66 | 31-35% | 67 |
| 66-70% | 115 | 36-40% | 43 |
| 71-75% | 87 | 41-45% | 33 |
| 76-80% | 96 | Above 45% | 20 |
| 81-85% | 38 | | |
| Above 85% | 15 | | |

The differential white blood count as tabulated in Table No. 9 was also essentially normal.

From these two tables it is seen that the blood counts alone are of no aid in making the diagnosis of Atypical Pneumonia, but when used in conjunction with the x-ray findings of pneumonia, the normal white blood counts favor the diagnosis of Primary Atypical Pneumonia. If the total count is elevated, however, and if there is a tendency to an increased percentage of neutrophiles one is more inclined to consider the pulmonic infiltration as a bacterial type of pneumonia. This seems to be the chief value of the white blood count so far as differential diagnosis is concerned.

## TREATMENT

The effectiveness of sulfonamides (sulfadiazine and sulfathiazole) in the treatment of Atypical Pneumonia was one of the chief problems which interested us while we were caring for this series. In Table No. 10 is presented a statistical review of the effect of sulfonamides upon the duration of fever and duration of hospital stay as compared to those cases which did not receive sulfonamides. The objection that these results might be weighted by the fact that only the more serious cases had received sulfonamides, was obviated by having all cases admitted to certain wards receive sulfonamide therapy regardless of their clinical condition, whereas all cases admitted to other wards never received sulfonamides. By referring to Table No. 10 it becomes obvious that sulfonamides had no beneficial effect in decreasing the duration of the disease nor of the fever. Moreover, we could observe no clinical evidence that the sulfonamides alleviated clinical symptoms. This paper presents another series to be added to the ever increasing number of reports stressing the ineffectiveness of sulfonamides in Atypical Pneumonia. It should be added, however, that where there is evidence of a secondary bacterial infection, as manifested by leucocytosis and recurrence of fever, the advisability of using sulfonamides should be carefully considered.

TABLE NO. 10

RESULTS OF SULFONAMIDE THERAPY

| | Number of of Cases | Days in Hospital | Days of Fever |
|---|---|---|---|
| Authors' 200 cases: | | | |
| Sulfonamides | 62 | 21.0 | 4,904 |
| No Sulfonamides | 138 | 20.5 | 4.048 |
| All other cases in this 630 series: | | | |
| Sulfonamides | 153 | 22.5 | 5,980 |
| No Sulfonamides | 277 | 19.6 | 3.556 |

The most effective form of treatment consisted of absolute bed rest except for bathroom privileges. In addition, supportive therapy and symptomatic medications such as aspirin and cough syrups or nose drops were used where indicated.

At the time this series of cases was being studied, Penicillin was not available for treatment of this disease. Therefore no statistical study was made with this drug. Suffice it to say that recent reports (such as Kinsman, et al., J. A. M. A. 25 Aug. 1945) generally concur that Penicillin has no place in therapy of

uncomplicated Primary Atypical Pneumonia. However, it should be used when this disease is very severe, and when secondary bacterial infection is present.

## COMPLICATIONS

Complications were relatively rare in this series. We have not compiled them statistically because of the difficulty in securing case reports of those who have left this Field. During the months that the above series of cases were being followed, the authors saw four cases of lung abscess, a few cases of pleurisy with effusion, and a number of cases of asthenia of many weeks' duration—all of these complicating Primary Atypical Pneumonia. During this period we did not see any cases of bronchiectasis, proven to have followed Atypical Pneumonia, although it is reasonable to presume that this complication could readily ensue upon the bronchiolitis noted in this disease. We have observed one case of toxic myocarditis, following Atypical Pneumonia, and we have seen several cases of erythema multiforme pluriorificialis occurring in association with Atypical Pneumonia. These complications will be further reported in a subsequent paper.

## CASE REPORTS

The following two case histories are presented as typical representations of mild and severe examples of this disease:

I. A 27-year-old Air Cadet, admitted 6 March 1943 complaining of a severe cough and tight feeling in his chest for one week. He had had a "cold" for two or three weeks and on the day before entry he developed a sore throat. Otherwise there were no symptoms, such as chills, fever, headache, photophobia, backache, anorexia, or GI symptoms. Examination showed a well-developed, well-nourished male who did not appear very ill. The nose was free of any mucoid discharge. The throat was slightly red. There were wheezes and coarse, moist râles over the right lower lobe, but no evidences of consolidation. The remainder of the physical examination was normal.

On entry his temperature was 99° and remained elevated up to as high as 101° for three days, following which it remained normal. His white blood count was 6,500 on entry with a normal differential, and on repeat one week after entry the white blood count was 7,200 with a normal differential. The x-ray of the chest showed the typical x-ray findings of atypical pneumonia of the right lower lobe, and it took approximately 16 days for the chest x-ray to become clear. The patient began to raise sputum on the day after entry, and by five days after entry felt completely well but was kept at bed rest until his chest x-ray had cleared. He was treated with bed rest, APC capsules, and elixir of terpine hydrate cough syrup. He was discharged to duty on the 23rd hospital day.

II. A 26-year-old Air Cadet, admitted 22 February 1943 complaining of a shaking chill, fever, dizziness, headache, sore throat, cough, and pains along the costal margins of the chest for one day. The onset was rather sudden. Physical examination showed a well-developed, well-nourished male who appeared moderately ill. There was a shaking chill during the examination. Skin was hot and dry. Eyes were clear. There was a mucoid discharge from the nose and the throat was injected. The chest was clear to percussion and auscultation. There was tenderness under both costal margins. The remainder of the physical examination was normal.

The temperature on entry was 102° and it remained elevated to as high as 103° for eight days, after which time it remained normal. The white blood count on day of entry was 6,500 with 58 per cent neutrophiles. Four days later the white blood count was 7,600 and on 6 March, some 12 days after entry, his white blood count was 7,900. X-ray of the chest on entry showed an infiltration of the left lower lobe, which had resolved about 90 per cent within 19 days after entry, but the x-ray taken on 13 March 1943, some 19 days after entry, showed a new, small area of atypical pneumonia at the right base. There was gradual resolution of both areas until the chest x-ray taken 26 March 1943, some 32 days after admission, showed complete resolution. Throat culture showed non-hemolytic streptococcus and staphylococcus aureus. The patient was quite uncomfortable during his first week in the hospital, having severe paroxysms of coughing which necessitated marked limitation of the respiratory excursions. In addition, there was marked generalized weakness.

On 1 March, about a week after entry, physical signs were noted for the first time, as coarse, moist râles in the left lower lobe. On 7 March, two weeks after entry, the patient felt completely well. His cough had subsided, but because of the persistence of positive x-ray findings he was kept in bed until the chest x-ray had cleared. The patient was discharged to a medical furlough on 31 March 1943, after 37 hospital days.

## SUMMARY

1. A statistical study of 630 cases of uncomplicated Primary Atypical Pneumonia is presented.

2. The disease as presented is a self limited type of acute respiratory infection, with infrequent, but occasionally severe complications. There was no mortality.

3. The average hospital stay was 20.4 days, dependent largely upon the persistence of positive x-ray findings for this length of time.

4. There were no presenting symptoms which could be considered diagnostic. Cough was present in 92.5 per cent of the cases, but had no identifying characteristics.

5. The temperature never rose above 103° in 75 per cent of the cases and lasted less than four days in 66 per cent of the cases. Before the end of ten days the temperature was normal in 97 per cent of the cases.

6. Physical signs were valuable for diagnosis when present, but were completely absent in 50 per cent of the cases on admission.

7. Both the total white blood count and the differential were within normal limits in the majority of the cases. It was of diagnostic value only when the possibility of a lobar pneumonia had to be considered.

8. Of all Primary Atypical Pneumonias, 86.8 per cent occurred in the lower lobes.

9. X-ray is indispensable in the early diagnosis of Primary Atypical Pneumonia. Without roentgen facilities, it is the belief of the authors that the most astute clinician will fail to diagnose a very large percentage of cases.

10. Sulfonamides seemed to have no effect upon the course of uncomplicated Atypical Pneumonia, but when there is evidence of a secondary bacterial infection the advisability of their use should be carefully considered.

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## THE PROBLEM OF THE CHRONICALLY ILL PATIENT

The existing facilities in most communities for the care of the chronically ill are inadequate, and a well planned and integrated service is needed. Before this can be accomplished, some clear thinking on the basic issues which are involved is necessary. A practical program for meeting the problems of chronic illness must look ahead far into the future. The problems involved are too big and too complex to give promise of any simple or early solution, and we must shape our activities toward long-term objectives. These objectives will of necessity be achieved through various approaches, chief among which will be:

1. The prevention and alleviation of chronic illnesses and the disabilities which they cause. This I have already discussed earlier in this paper. To reiterate, the medical profession is interested both in the prevention and in the treatment of chronic illness.

2. The provision of institutions and other facilities and services for the care and treatment of patients already disabled by chronic illness.

3. A sound method of meeting the costs of care for those patients who are financially unable to meet their own expenses.

Before any sound program can be instituted, careful and serious consideration must be given to the fundamental questions, as:

1. The relative distribution of responsibility which should be maintained by voluntary, philanthropic and proprietary services for establishing and operating the necessary homes and hospitals.

2. The responsibility which should be assumed by the government for the indigent.

3. The desirable size and location of the facilities to be established.

4. The extent to which beds are needed in hospitals or treatment centers as distinguished from homes for patients who cannot hope to profit from treatment and need only continued personal care and nursing attention.

5. The most satisfactory method of financing care for patients unable to pay the costs of care, in whole or in part.

6. The most effective means of maintaining adequate standards of care in institutions serving these patients, i. e. through licensing laws, periodic inspection by state or local authorities, and so on.

Whether there are to be special institutions for the chronically ill, i. e., chronic disease hospitals separate and apart from those serving acutely ill patients, or whether they are to be separate wings or additions to these hospitals. Much discussion must be given to this question.—Kretschmer, J. A. M. A., Vol. 127, No. 16, p. 1025.

# APPENDICITIS

Franklin W. Rice, M.D., F.I.C.S., Morristown, N. J.

Several years ago Horsley stated that there were 16,000 deaths a year from appendicitis in the United States. Since the advent of the sulfa drugs, along with suction drainage, this mortality over the past three years in the average clinic has been cut in half. There is still room for improvement. Part of this death rate is due to the public, and also in turn, faulty surgical technic has caused occasional operative deaths.

Splendid work was done by Bower in Philadelphia several years ago in producing a statewide survey of appendicitis and its complications. The mortality rate in spreading peritonitis was reduced from an average of 3.5 per cent to 2 per cent. Some clinics six years ago had as high a mortality as 20 per cent, but with improved pre-operative and post-operative care, better results have been obtained, and today an operating surgeon has to give a good excuse if he loses a case. Deaths from appendicitis have been caused by peritonitis, pneumonia, abdominal distention from peritonitis, intestinal obstruction, myocardial disease, embolism, uremia, etc.

The ideal operation should consist of:

1. Operation as soon as the diagnosis is made, no matter what the condition of the appendix is, whether ruptured or general peritonitis is present, or if an abscess is found by doing simple drainage;
2. Gentle handling of all tissues using a suction apparatus in place of sponging;
3. Obtaining physiological rest of the intestines by decompression with the Wangensteen or the Levine tube, and not by enemas or colonic irrigations.

Once the diagnosis is made it is better to operate on all cases of appendicitis except those in which the patient is in a moribund condition. No one can tell how serious the situation may be until the abdomen is opened. A policy of delay will in many cases mean perforation and spreading peritonitis. It must be understood that the case should be studied and prepared thoroughly.

Twenty-five years ago many patients were sent to the operating room who were dehydrated and had been desperately ill for two or three days before being sent to the hospital, so that many of these died because of lack of proper preparation. Today the mortality has been lowered by the fact that these patients receive pre-operatively:

1. Fluids with glucose to restore glycogen balance;
2. Wangensteen suction drainage;
3. Sedatives such as morphine;
4. Treatment for shock, including plasma;
5. Transfusions when indicated;
6. Proteins if the patients have hypoproteinemia;
7. Chlorides if alkalosis is present;
8. Maintenance of acid-base balance by injection of glucose, sodium lactate, saline and inhalations of oxygen.

The patient is brought into the operating room with the intravenous fluid needle still in the vein, and if the abdomen is distended from advanced peritonitis, a Levine tube should be used.

Spinal anesthesia is the anesthesia of choice but some patients do well on intravenous pentothal or gas-oxygen-ether. In order to secure the best teamwork and coöperation for the patient's benefit the custom of the hospital should prevail.

Throughout the United States practically 75 per cent of appendices are removed through the McBurney incision and the remaining 25 per cent either through a right rectus or a low transverse incision. According to Vosburgh, "It is of interest to note that McBurney in the early '90's used his incision only on interval cases and said it should not be used in acute emergencies." However, it is at present used by most surgeons in acute cases and some other incision is used where any exploration is contemplated or the diagnosis is at all doubtful. It is very easy to extend the McBurney incision upward if the appendix is underneath the liver, and also downward if the appendix

is placed in the pelvis. Mechanically, the McBurney incision is better for drainage.

There has been a conflict of opinion on the question of drainage since the introduction of the sulfonamides. Mason and Allen state that they believe that intraperitoneal drainage is indicated only when there is gross and foul-smelling exudate in the peritoneal cavity. The mortality rate in cases of peritonitis in which drainage was not instituted was found to be slightly lower than in those in which drainage was used, but the number of cases reported is admittedly too small to permit dogmatic conclusions. Hoerner, in discussing acute diseases of the abdomen, states that there has been more and more of a tendency in recent years not to start drainage after removal of a ruptured appendix. The exponents of this practice believe that it is impossible to drain the entire peritoneal cavity, and that the drain acts as an irritating foreign body which hinders the natural defensive processes of the peritoneum. This may be true so far as generalized peritonitis is concerned. However, until more conclusive evidence is offered as to the lack of necessity for drainage in the more localized types of peritonitis, it is better to insert a soft rubber split-tube drain for a four- to eight-day period. Such a drain rapidly establishes a sinus tract and is the only method which encourages drainage instead of blocking it. Drainage should be used in the following types of cases:

1. If broken-down tissue which might cause a residual abscess has been left in the abdomen.

2. If the appendix is not removed because of an abscess.

3. If there is bleeding from the mesoappendix or adjacent organs that has not been satisfactorily controlled.

4. If the ileum or cecum has been traumatized in removing the appendix.

5. If there is diffuse spreading peritonitis.

6. If there is doubt about the security of the ligature around the appendiceal stump.

7. If there has been a break in the operative technic by the surgeon or assistant.

8. If residual abscesses are found anywhere within the abdominal cavity.

### POSSIBLE SURGICAL ERRORS BY OPERATING SURGEON CAUSING MORBIDITY AND SOMETIMES MORTALITY

1. Nicking of the intestine during opening of the peritoneum, causing infection.

2. Nicking the intestine while cutting the mesoappendix.

3. Nicking open the appendix or cecum while severing the mesoappendix, causing spillage of infected material.

4. Too deep a needle bite with a purse-string suture through the cecum.

5. Hematoma in cecum from pressure by gauze pads, pulling carelessly on retractors, clamping large intestine with sponge holders to draw the cecum out of the wound, or pinching intestines too tightly with fingers.

6. Slipping of ligature around mesoappendix.

7. Slipping of the ligature around the appendix.

8. Using an excess of chemicals such as phenol, causing perforation of the bowel.

9. Burning the stump too low in cecum with cautery, causing sloughing.

10. On suturing wound, unintentionally catching a loop of bowel in the peritoneal stitch.

11. Placing drains in the wrong position in the abdominal cavity.

12. Using too hard a rubber tube for drainage.

13. Spreading sulfa drugs too thickly in spots rather than powdering uniformly and lightly over the intestine.

14. Leaving bleeders in the abdominal cavity or abdominal wall.

15. Making the incision too short or too long or placing it inaccurately.

16. Leaving sponge within the abdominal cavity or the incision.

17. Taking drains out too soon; if drains are used, they should be left in at least four to eight days. However, drains left in too long may cause fistula and sinus tract.

18. Ordering enemas or irrigations the day after operation for an acute appendicitis.

19. Not maintaining fluid balance — poor pre-operative or poor post-operative care.

20. Suturing ileum to cecum when using a purse-string stitch, thus causing kinking of the bowel and partial obstruction.

21. Delaying operation because of an inconclusive or misleading total leukocyte count.

22. Rupturing the appendix with finger while attempting to bring appendix out of abdominal cavity.

23. Allowing pus to spread through peritoneal cavity when opening abscess for drainage.

24. Doing an ileostomy or cecostomy in spreading peritonitis in place of using a Wangensteen or Miller-Abbott tube.

25. Lack of daily visits by surgeon to patient during hospital stay.

26. Insufficient assistance at the operating table.

DIFFERENTIAL DIAGNOSIS OF ACUTE APPENDICITIS

| | Conditions | Main Differential Diagnostic Points |
|---|---|---|
| 1. | Acute gastroenteritis | Dietary indiscretion, diarrhea. |
| 2. | Gallstones | Roentgenographic findings, gas pains, vomiting. |
| 3. | Acute cholecystitis | Pain radiating from gall-bladder, sometimes jaundice. |
| 4. | Renal colic | Blood in urine, backache. |
| 5. | Acute pancreatitis | Findings in blood and urine amylase test. |
| 6. | Ectopic pregnancy | Missed menstrual period, spotting, bleeding. |
| 7. | Intussusception | "Step-ladder" roentgenogram, vomiting, and no passage of gas. |
| 8. | Pneumonia | Pulmonary roentgenographic findings, signs of consolidation, cough. |
| 9. | Pleurisy (acute) | Roentgenographic findings and physical signs in chest. |
| 10. | Tuberculous peritonitis | Pulmonary findings, elevated night temperature. |
| 11. | Perforated peptic ulcer | Shock, severe pain, roentgenographic appearance of diaphragm. |
| 12. | Hydronephrosis | Pus in urine, chills and fever, results of cystoscopic examination. |
| 13. | Meckel's diverticulum | Mass near umbilicus. |
| 14. | Twisted ovarian pedicle | Results of combined abdomino-vaginal examination, mass in right or left lower quadrant. |
| 15. | Internal hernia | Early signs of obstruction, appearance of inguinal rings. |
| 16. | Constipation | History of constipation, relief with enemas. |
| 17. | Mesenteric thrombosis | Occurs more often in older people; endocarditis present. |
| 18. | Intestinal obstruction | No gas passed by rectum, vomiting of fecal contents. |
| 19. | Hysteria | No abdominal rigidity, normal blood count. |
| 20. | Gonorrheal salpingitis | History of venereal exposure, positive vaginal smear, relatively low polymorphonuclear neutrophil leukocytosis. |
| 21. | Acute exanthemata | Sore throat, rash, general abdominal pain. |
| 22. | Right hip arthritis | Roentgenographic picture, low blood count, history of joint disease. |
| 23. | Lead colic | Findings in urine test, blue line on gums, stippled red blood cells. |
| 24. | Mesenteric lymphadenitis | Occurs mostly in young children; history of sore throat, low blood count. |
| 25. | Pyelitis of right kidney | Pus in urine. |
| 26. | Ptosis of right kidney | Roentgenographic findings, intravenous pyelogram. |
| 27. | Rupture of Graafian Follicle | Low blood count, history of fainting. |
| 28. | Dysmenorrhea | Pain occurring periodically before or during menstruation. |
| 29. | Tabes dorsalis | History of syphilis, positive Wassermann and Kahn test results, nerve symptoms. |
| 30. | Diabetic acidosis | Blood sugar findings, positive carbon dioxide test result. |
| 31. | Coronary thrombosis | Electrocardiographic findings, shock. |
| 32. | Inflammation of undescended right testicle | Palpation of inflammed mass. |
| 33. | Phlebitis of the right iliac vein | Varicosities in leg, inflammation of the uterus. |
| 34. | Volvulus of cecum | Diffuse mass seen roentgenographically. |
| 35. | Carcinoma of cecum | Roentgenographic findings, low red blood cell count, persistent pain. |
| 36. | Perforation by foreign body | Recognition of foreign body by history, roentgenographic examination, etc. |
| 37. | Dysentery | History of exposure, examination of stools. |
| 38. | Allergy | History of allergic reactions, and results of skin tests. |
| 39. | Abdominal migraine | History, blood count, neurologic findings. |
| 40. | Psoas abscess | Roentgenogram of spine, aspiration. |
| 41. | Henoch's purpura | History of hemorrhagic manifestations; positive tourniquet test. |
| 42. | Regional ileitis | Gradual symptoms of intestinal disease. |

PATIENT'S ERRORS

1. Use of cathartics, purgatives, and laxatives, because of pain in abdomen.
2. Use of enemas and high irrigations for abdominal pain.
3. Calling a surgeon too late for operation.
4. Mistakenly believing that an appendix can be frozen.
5. Continuing at business or occupation until condition has progressed too far.
6. Refusing surgery for various reasons, such as religious belief.
7. Trying every remedy that a neighbor or relative may suggest instead of obtaining expert advice.
8. Attributing symptoms to neurotic tendencies.
9. Lack of sufficient confidence in operating surgeon, causing a delay in operation.
10. Shopping from doctor to doctor trying to save surgeon's charges.

CHEMOTHERAPY

The sulfonamide group was introduced into surgical practice as specific for infections due to hemolytic streptococci. Since the original work on streptococcus sore throat started in England, this group of drugs has been used for many infections, such as meningococcus, colon bacillus, the Welch bacillus, gonococcus, etc. There are several factors that are important in determining what drugs are best used in appendiceal peritonitis. Meleney, Altemeier, Bower and others, have found that the predominant organism has been a colon bacillus infection, along with streptococcus viridans, streptococcus haemolyticus, anaerobic streptococci, Welch bacillus, etc. It is the sulfa drug that has an effect on the streptococcus germ as found in a ruptured appendix.

Since 1936 Ravdin, Rhoades and Lockwood have used sulfanilamide in acute suppurative appendicitis in one-third of all their cases, generally using one of the sulfa preparations for the more advanced malignant peritoneal infections. They have reduced their mortality from 1.4 per cent to .4 per cent in a series of 800 cases. The statement has been made that the sulfanilamide therapy is to be used in any case that is to be drained, although Babcock at Temple University has used a "sump" drain in peritoneal infections that he states is equal to the sulfa treatment. In the pre-sulfa era in 34 cases of perforated appendix, Burnett had a mortality of 35 per cent, and after the treatment with sulfonamides had started, the mortality had been lowered to 9.6 per cent in 62 cases.

To omit the use of sulfonamide drugs in the therapy of appendicitis is to invite complications which otherwise could be avoided. Sulfonamides have a place in the treatment before operation, in the wound at the time of operation, and in the post-operative convalescence.

Pre-operative Use: The aim of pre-operative use of intravenous sulfonamides is to obtain optimum circulating blood levels by the time intervention is undertaken. The superiority of sulfadiazine has been emphasized by Walter and Cole. A blood level of 9 to 12 mg. per cent is aimed at. This usually requires from 5 to 9 gm. per day, but the quantity will vary. The pre-operative administration must be done without unnecessarily delaying the operative removal of the appendix. Since it is mandatory that adequate fluid intake be maintained, the drug may well be given in physiological saline solution.

| | |
|---|---|
| Sulfanilamide | 8 to 10 mg. per 100 cc. |
| Sulfapyridine | 10 to 12 mg. per 100 cc. |
| Sulfathiazole | 4 to 6 mg. per 100 cc. |
| Sulfadiazine | 10 to 12 mg. per 100 cc. |
| Sulfamerazine | 10 to 15 mg. per 100 cc. |

When sulfapyridine, sulfathiazole or sulfadiazine is being administered, it is advisable to also administer sodium bicarbonate at the same time. If this procedure is carried out, the incidence of renal complications is reduced.

Use in the Operating Field: Sulfadiazine, when placed in the peritoneal cavity and in the abdominal wall, should be so placed that it is immediately in solution; otherwise it simply becomes another foreign body. It is usual to place 4 gm. in the peritoneal cavity and 2 gm. in the abdominal wall.

Post-operative Use: The sulfadiazine treatment should continue until the danger of complications is past, or until the septic phenomenon which is present has subsided. The quantity in each dose will depend upon the blood

level, and this is dependent upon the quantity used before the operation and in the operative field.

At the Mayo Clinic, peak concentrations of 10 to 23 mg. of sulfanilamide and 4 to 10 mg. of sulfathiazole per 100 cc. of blood were obtained four to eight hours after intraperitoneal deposit of 10 gm. of the drug. After 24 hours the concentrations of sulfanilamide ranged from 4 to 8 mg. per 100 cc. of blood while the concentrations of sulfathiazole were 1 to 3 mg. per 100 cc. From their study, sulfathiazole administered intraperitoneally has a more prolonged local action than sulfanilamide. When sulfathiazole is spread thinly over the peritoneal cavity, as much as 35 per cent is excreted during the first 24 hours. From their experience, if the drug is spread, its absorption and excretion take place much more rapidly than if concentrated in one spot; however, "dumping" the drug at a desired point obtains high local concentration at that point, and this is the method used in most cases at the Mayo Clinic. In 1936 to 1938 there was a mortality rate of 16.9 out of 166 cases; after the use of the sulfa group of drugs in 1940 to 1942, there was a mortality rate of 3.8 out of 132 cases.

### CONCLUSIONS

Only by teamwork can the operative mortality in appendicitis be lowered.

The laity must coöperate better in calling the surgeon.

Surgical pre-operative care must be carried out on the same basis as in a gastric or gallbladder or any serious abdominal operation, and appendicitis should not be relegated to the house staff for full care.

Surgical technic should be improved and chemotherapy, since it has lowered markedly the mortality rate in the United States, should be given first preference.

Finally, each patient is an individual and so is the attending surgeon; so that daily visits should be conscientiously made so that postoperative complications will be cut to a minimum.

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## FROM A LAY MEDICAL REPORTER

Deep in Germany
30 April, 1945

Dear Doctor:

I'm not sure I'm quite capable of writing a coherent letter just now but I must express my indignation somehow, and writing is my only medium of expression. I have just returned from a German concentration camp for Jews—Polish, Russian, French. Their nationality didn't count. Only they were Jews.

They were all liberated—all those that I saw—because they were all dead. Yes, there were more than 300 of them laid out on the ground in the front yard of the camp in the neat orderliness so characteristic of this German master race. Adjacent to them were two large excavations prepared for a mass burial.

The bodies of these victims, many of them hacked and dismembered, had been gathered from the surrounding woods and countryside within a radius of two and three kilometers by prominent Nazis of the neighborhood at the urgent behest of American bayonets.

The American soldiers found the bodies of these wretches beside the graves in odd spots in the woods and fields which their tormentors had forced them to dig for themselves. As these starved creatures dropped from exhaustion, they were malleted, clubbed and hacked and then pushed into the excavations they had dug.

In the midst of these dead laid out by their "super-men" neighbors was a Nazi Waffen SS trooper. He who had lived by the sword died by it—he had been clubbed to death the day of the arrival of our troops by the despised Polish cook who had been kept alive only because he was useful for the time being. It was good to see him lying there, battered and bruised, his hated black uniform stained with blood.

The liberating American force arrived too late to save many of the victims. None of the pitiful few that were left could hold the food that was given to them. The boys said they kept dying before they would get them out of there to cleanliness and light. Those that did die at least had the satisfaction of knowing that the indescribable spectacle of their wrong would at last be known to the world. As if that were any satisfaction in a crime so enormous!

There were eleven camps like this, all in the vicinity of a large southern German city which I can't name for reasons of security. In all there were 4,000 prisoners, the Storm Trooper clubbing cook told the boys. The Americans found only 300 alive.

From one of the guard towers I could see other burial spots in the front yard which served as an unmarked cemetery of oblivion. Behind this yard were crude barracks sunk deep in the ground with only the gables of their dirt-covered roofs showing. Many of the thirty or more shacks were burned by the Nazis at the onsweep of our forces with the bodies of the living and dead wretches they sheltered still inside.

And the earth that camouflaged the roofs of the barracks that were their pyres covered lightly their charred bones. The embers of one of the shanties used in this carnal roast were still burning when I got there.

Over the whole area, despite a cold brisk wind, there hung a leaden stench that no amount of fresh air could seem to cleanse. And the enclosure was only about 1,000 yards square.

On the gate of the double barbed-wire fence was an "Off Limits" sign fortified by armed GI guards. An American captain explained that the camp was so infested with lice and typhus that it would be too dangerous to enter.

"Listen, Sergeant," he said, "Do you think I'd even stand here if it weren't for duty."

The guards and other GIs that were in the area were understandingly silent. There was no clowning, no horse-play. Behind them within the barbed wire were lying the rows upon rows of human beings whose sufferings were ended, whose story was told.

Glancing at them, I could hardly believe they were the victims of whom I'd heard. I walked along the fence to a point where they were closer. I believe now.

Accustomed both as a reporter and soldier to the sight of death, I found these dead to be different. They were gaunt skeletal forms that by their very refusal to putrify were a symbol of the strength of human beings to hold out and cry out even in death against the evil that engulfed them.

They lay in the various contortions of pain in which death had relieved them. One fellow had the back of his hand pressed closely against his mouth as though to ward off another blow or perhaps stifle a scream. None of their faces were covered and many of them were stark naked, their gaunt arms and legs forming crazy patterns. And true to his faith to the bitter end, one corpse still wore his black shievist cap.

Is this the 20th Century? I'm not sure any more.

One of my teammates who the night before had captured four Waffen SS men summed up our attitude on the return trip with the simple announcement, "I'll never take another Storm Trooper alive."

In view of the above flowering of German culture and good order it goes hard for GIs to listen to well-meaning officers lecture against the petty larceny of wine and odd souvenirs which is labeled "looting". Looting be damned! These birds have been systematically looting a continent for five years. As a result, they have a standard of living superior to our own. While those at home have been hunting for various items, these pigs have groveled in the best of everything.

I wish you could have visited the country estate, resembling a feudal mansion, of a bitters king that I saw. The guy was only small fry in the German hierarchy, but nonetheless enjoyed the loot of the museums of Europe. You should have heard him beef because some GIs appropriated some articles they needed.

Recently I've been driving my captain on liaison. The front has been moving too fast for photo interpreters and so we've taken to helping out with liaison. It has given me rare opportunities to see the country and not a few close shaves with the enemy. One of the most interesting places we stumbled on was a section of an autoban that was turned into an air-strip beautifully camouflaged against the detection of just such guys as ourselves. Cleverly hidden under the trees were a dozen or more jet-propelled planes, one of them captured intact.

This is all over but the shouting. I hope I can get back to civilian life doing something worthwhile. I'm inclined to think that I'll specialize even more in medical reporting. I don't like some of the work that is being done and I have some ideas of my own about how the job should be handled.

This letter, written only a few days before the surrender of Germany, depicts the morbid conditions of a concentration camp. Of course, it is of no direct medical value, but would certainly impress anybody with a necessity for supporting our democratic form of government and our American way of life within the medical profession or within any other scope of function in this country.—*Editor.*

# SHOCK THERAPY — 1937 TO 1944 *

John H. Taylor, M.D.
New Jersey State Hospital, Trenton, N. J.

Trenton State Hospital began using shock therapy in March of 1937, initiating the treatment with a group of eight male patients who were subjected to insulin. This group was rapidly enlarged until at present the shock therapy unit has a capacity of 128 beds. For the past five years we have made it a practice of having 64 patients at all times on insulin therapy and its modifications. As stated, our first form of shock therapy was insulin and this remains our prime shock producing agent. We have tried various degrees of coma, numbers of treatments and have reached the conclusion that the best results are obtained from using large doses and continuing the treatment for 50 treatment days, including the slow building up of the coma producing dose and a four or five treatment reduction. We have given as high as one thousand units but usually our maximum dose is three hundred units. This is given early in the morning and an effort is made to produce a coma three hours later and allow the patient to remain in that coma for a period of one hour.

The second shock producing agents used, beginning in the fall of 1937, were metrazol and large doses of camphor to produce epileptiform convulsions. We first used these agents alone but rapidly abandoned their use because of the large number of fractures occurring. In addition, the convulsions produced by the camphor came at unpredictable times and could not be as readily controlled. We then began using metrazol in addition to insulin, producing an epileptiform convulsion of the grand mal type, in the third hour of the insulin shock. This eliminated the fear which caused the patient to resist the treatment and which, in our opinion, is partially responsible for some of the severe skeletal injuries following such treatments. Curare was also used with metrazol but in our experience the dose of curare needed to cushion the shock was too critical and in a few cases there was a respiratory paralysis requiring several hours of artificial respiration. The fear accompanying metrazol injections was still present with the use of curare and caused a marked antagonism to both the treatment and the physician.

In 1940 we substituted electric shock for metrazol and are now using it in the manner described below. We, at first, used electric alone on manic depressives, involutional psychoses and catatonic schizophrenics and, while we found a rapid spectacular improvement, the patients showed a large instance of relapses following the discontinuance of the electric shock. We now use electric only in combination with insulin on the acute cases, our experience being that the electric initiates the improvement and the insulin sustains it.

In 1941 we began using histamine according to the method devised by Horace Hill, in cases which had not responded to the combined insulin and electric shock treatment. We soon found that Hill's dose of .5 mm. to 3.0 mm. could be safely worked up to as high as 12.0 mg. Histamine produces a profound cardiovascular storm in which there is a rapid emptying of the great vessels and a marked dilatation of the capillaries, with the patient becoming markedly erythemic. There is a rapid fall in blood pressure and the pulse becomes rapid and somewhat thready. This condition will last for from five to eight minutes and the patient showed a rapid return to his normal vascular equilibrium. This method gave us very good results in approximately 25 per cent of the cases who had been failures from insulin and electric shock and, as soon as we are able to secure sufficient nurses, we intend to resume it on a larger scale.

Another form of shock therapy used was a Faradic current produced from a Ford spark coil. This produces a tonic spasm which is only present as long as the current flows. We found no definite indication for the use of this type treatment except in one case of hys-

* Presented at the Fall Meeting of the N. J. Neuro-Psychiatric Association on November 15, 1944.

terical blindness and two of hysterical paralysis which showed rapid recoveries following its use.

We have recently been using a so-called electro narcosis, consisting of a low milliamperage applied over periods of from thirty to sixty seconds but we have not had sufficient experience with it to evaluate its true worth. We have, however, noted that for disturbed cases, it is not as efficient in producing a quick response as the regular electric shock. The principal effect noted was a marked cyanosis.

At this point we would like to emphasize that all methods of shock therapy have some potential value and, in our present state of knowledge, we think it unwise to neglect the use of one method in preference to another.

The shock therapy patients in the Trenton State Hospital are separated from the general hospital population. Their food comes from separate diet kitchens; it is served to them on the wards, and in the afternoon, following treatments, an effort is made to have them partake of the occupational and recreational activities of the hospital. We are at present treating 85 per cent of the first admissions of all functional psychoses and neuroses. The 15 per cent not treated are patients whose families refuse permission or who have a physical defect and a few voluntary patients who do not remain in the hospital long enough to begin treatment. As is customary at the Trenton State Hospital, all cases showing physical defects or infections are given the necessary surgical or medical care before instituting shock therapy. The patients are not subjected to any form of psychotherapy and interviews are held only sufficiently often to arrive at a diagnosis and to determine if the patient is in condition for release. We consider hallucinations, delusions, emotional disturbances, etc., as a disturbance of a physical function and as the functioning improves the symptoms will disappear without, or in spite of, psychotherapy.

Up until June 30, 1944, we had completed treatment on 1605 acute cases; of these 27 died, all while undergoing insulin therapy; 49 were stopped because of the development of a physical condition, leaving 1529 completing treatment. Of these, on that date, 1053 were in the community, or 68.6 per cent, and 476, or 31.4 per cent, remained in the hospital. Of the 1053 who were out of the hospital, 999 had shown no return and 54 had returned, received further treatment and had again been released. Of the 476 in the hospital, 93 had been released, returned and failed to respond to further treatment.

The three principal psychoses treated were, of course, schizophrenics, manic depressives and involutional psychoses.

Of 788 schizophrenics who completed treatment, 475, or 60.3 per cent, were in the community; 313 were in the hospital. Of the 341 manics completing treatment, 288, or 84.4 per cent, were in the community. Of these, 271 had remained out without return, some as long as seven years, while 17 had shown a return of their mental symptoms, and on receiving additional treatment, had again been released. Of the 53 remaining in the hospital, 16 had left the hospital and were back in residence on that date, following a return of their psychotic symptoms, leaving only 37 out of 341 who had failed to respond sufficiently to leave the hospital on parole.

In the involutional group, out of 140 patients, 105, or 75 per cent, were in the community. Of these, there were three who had returned and required treatment. Of the 32 remaining in the hospital, eight had been released, returned and were still in residence. The most important factor in treating involutional psychoses was the shortening of the period of hospitalization. This observation applies as well to the manic depressive psychoses, most of them being able to leave the hospital within approximately twelve weeks.

An interesting contrast can be made by checking the number of patients released from the hospital within two years following admission in the period before shock therapy was instituted. Using 1935 as a control year, the hospital records show that at the end of two years, 35.2 per cent of the first admission schizophrenics were in the community, compared to 60.3 per cent in 1944. In the manic depressives admitted in 1935, 61.2 per cent of the first admission manic depressives were in the community, compared with 84.4 per cent.

In the involutional psychoses, 30 per cent, as compared to 75 per cent.

Another large group of patients treated with electric shock alone were the disturbed, deteriorated schizophrenics of long duration. These were treated in large groups with no expectation of improving them to the point of leaving the hospital, but with marked success in improving their ward adjustment. Patients who had been untidy, destructive to clothing, would remain clothed and, in most cases, could be kept out on the open ward. A large number improved to the point of taking part in occupational therapy activities and, while no permanent results were obtained, the improvement in their hospital adjustment was sufficient grounds for continuing giving them electric shock. It was noted, however, if the treatment was stopped, the patients rapidly reverted to their former state.

In the past several years, 11 cases with syphilitic meningo-encephalitis, who were admitted to the hospital in an excited state, were treated with electric shock soon after their admission. They all rapidly quieted down and, as soon as the diagnosis was confirmed by laboratory findings, they were placed on malaria therapy. It is, however, interesting to note that, although no conclusions can be drawn from it, all of these patients were able to leave the hospital in an improved mental state.

Most epileptics in New Jersey are treated at Skillman. However, the Trenton State Hospital always has in residence some of the ones who are subject to violent furors or who have homicidal tendencies. These were given courses of electric shock and it was observed that in most of these cases the spontaneous convulsions stopped and the patients made a much better adjustment on the ward. In 1942 we reported a case, before the Philadelphia Psychiatric Society, of a man who had been subject to epilepsy for thirty years, usually having seizures approximately every other day. On September 2, 1941, he had five seizures. This gradually increased and, from the 6th to the 13th, he averaged ten seizures a day. On that date he was given an electric shock treatment. The following day he had ten seizures and another electric shock treatment was given. That day he had but one seizure. A regular course of electric shock was instituted and the patient given fifteen treatments. He remained free from convulsions until January 11, a period of four months. At the end of that period he began to have seizures every other day, but we were unable to resume treatment as the family withdrew their permission.

At this time our practice is to give all acute cases insulin therapy and, if they do not show marked improvement at the completion of twenty insulin shocks, to add electric to the insulin in the third hour of the insulin coma. However, with manics, markedly agitated involutionals and catatonic schizophrenics, we begin the electric and insulin concurrently.

In conclusion, may we state that many of the unfavorable results reported from shock therapy are frequently from physicians using very small doses of insulin, sub-convulsive amounts of electric and who fail to give treatment over a sufficient period of time; or who insist that one form of shock therapy be used in preference to another and who do not use them in combinations when the progress of the patient indicates the need of further stimulation. Finally, as stated before, all forms of shock therapy have a potential use and failure to respond to one type does not indicate the patient will fail to respond to another.

## DISCUSSION

Dr. Handelman (New Jersey State Hospital, Marlboro): At Marlboro we have not had as high a percentage of cases returned to the community as Dr. Taylor has been able to report. These are our figures: In 1943 of 1,116 cases treated, only 55 per cent have been returned to the community.

In September, 1942, we were forced to abandon the use of insulin because of lack of personnel, and of course our recovery percentage has not been as good since then.

We have to report that so far our results with electroshock used with manic depressive, manic cases, have been disappointing.

It is my feeling that the way electroshock works is in the manner with which it dulls the sensorium so that you do not have the anxiety forcing itself constantly to the forefront.

Dr. Esposito (New Jersey State Hospital, Greystone Park): We have treated a good many cases with not only insulin shock therapy but also metrazol and electroshock therapy. It has been my feel-

ing after observing a large number of these treated cases that the most important factor to keep in mind is the question, "What does the patient return to in the community after having had electroshock treatment?" In considering the statistics reported by others, it is my feeling that where it has been possible for the environment to be changed, electroshock was given the credit for the cure; while on the other hand, if they did poorly because of inability to change the environment, electroshock was blamed for the failure!

I partially agree with Dr. Taylor that psychotherapy is of less value during electroshock therapy because of the memory defect that develops as a result of the treatment, so that the patient does not have a chance to evaluate or adequately apply the psychotherapy. However, a short time following the cessation of electroshock treatment, psychotherapy is of real value, and it is also of value between short courses of electroshock therapy.

We usually start treatment with insulin in dementia praecox cases and after 20 or 25 comas, we usually change to electroshock. In the case of depressions, however, we find these cases respond equally well with electroshock alone, though in very debilitated cases we like to give insulin in addition to build them up.

We have found that continued intensive insulin treatment of long standing hospitalized dementia praecox cases, even knowing that patients will not leave the hospital, makes it easier for the nurses to handle these cases.

Our results have been good in using electroshock with manic depressive, manic cases; in fact, 85 per cent of all those cases treated have been returned to the community. It must be recalled, however, that such cases may relapse.

MAJOR PRESBERG (Veterans' Facility, Lyons): We have only been using this treatment for a year. In some cases we have given as many as 80 or 90 shock treatments to a single patient.

I have been following Dr. Kalinowsky's recommendation of giving them a strong dose from the start. I use a longer time unit with lower voltage, and this method seems to successfully decrease the number of spinal fractures we have had more recently. We start with 70, 80 or 90 volts for 2/10 second. We have given as many as 90 treatments in one day at our hospital.

DR. HENRY G. SMITH (Essex County Hospital, Cedar Grove): We have had poor results with insulin and we gave up metrazol shock because it seemed that electroshock was better.

During the past year we have treated 129 new cases. Fifty-three per cent of these are now out of the hospital. It is my feeling that electroshock is due the credit for this.

I use frequently repeated shock of small voltage. That seems to get the best results. We start with 70 volts, raising gradually until convulsion occurs.

We have not had any good results to speak of in the treatment of dementia praecox by electroshock, even though 60 or 70 treatments were given in certain cases. However, this treatment does bring about a better adjustment of the patient to hospital regime.

Our most startling results have been in the case of involutional melancholia treated by electroshock. Of 18 cases treated, 15 have recovered sufficiently to be returned to the community.

We have also had marked success in treatment of post-partum psychoses with electroshock, having recoveries in practically every case with the use of from six to twenty-four shock treatments.

DR. EMIL FRANKEL (Statistician, New Jersey State Department of Institutions and Agencies): I bring to you Commissioner Ellis' hearty approval of the program of shock therapy being used in our County and State hospitals. The Commissioner regrets that necessary consultative duties during this war emergency prevented his attending this meeting.

Because of the fact that we all note a difference in the approach to patients in the hands of different doctors, such as the number of electroshock treatments given, the dosage, etc., we do need, therefore, to record the variations in methods if we are to be truly scientific in our approach to the question of shock therapies. The statistician, as you know, has a passion for uniformity.

I had been interested in looking into the question of just how New Jersey compared with the United States hospitals in general on this question, and therefore present the recent figures on discharges from mental hospitals as a whole, as given in the latest report just received, as compared to our New Jersey figures:

| | United States | New Jersey |
|---|---|---|
| General Paresis | 40 | 46 |
| Alcoholics | 79 | 95 |
| Inv. Melancholia | 58 | 62 |
| Dementia Praecox | 58 | 67 |
| Paranoia | 54 | 55 |

Taking the figures as a whole for each 100 patients admitted, 52 are released to the community from hospitals in general throughout the United States, as compared to 55 released from our New Jersey hospitals.

One other statistic is worthy of note; of the treated cases in our New Jersey hospitals, 79 per cent have left the hospitals, whereas only 58 per cent of the untreated cases have been released.

DR. L. KALINOWSKY: I feel that Dr. Taylor's paper is one of the best I have heard on shock treatment.

A recent report from Iowa stated they did not get good results with shock treatment. I believe the reason for this is that they did not give a sufficient number of treatments, as they reported only 30 convulsions in the average case.

One can begin the treatment with elcctroshock and then give insulin, and I favor this because it gets the patient out of his acute depressed state more quickly.

There will be more relapses in cases treated by electroshock alone than there will be with those cases who receive insulin as well.

It is important to remember that whereas we do see improvement after the fourth electroshock treatment, we should not make the mistake of stopping treatment at that time.

Gialetti, the Italian doctor who first used this treatment, insisted upon from 20 to 35 electroshock treatments.

Today the combined treatment of insulin hypoglycemia followed by electroshock is undoubtedly the best plan of treatment.

The recent New York State report which has been given so much publicity has brought up many questions for discussion. One point in particular is that only a few years ago, according to Statistician Malzburg of the New York State Department of mental Diseases, only 21 per cent of *untreated* dementia praecox cases were released from the hospitals; yet in the recent report on insulin shock therapy, it is asserted that 58 per cent of the *untreated* cases of dementia praecox were released from state hospitals. One must wonder why the sudden change in the statistics with only a three-year difference between the two.

It is my feeling that if a patient does not respond after four or five electroshock treatments, he will not respond from a prolonged course of treatment.

In Switzerland they give four or five convulsive treatments and then go on with insulin treatments in those cases which seem to respond to the short course.

In my opinion the manic depressive, manic case, does respond to treatment if the treatments are given close together.

Dr. Kinley: Dr. Kinley remarked that although he had felt shock treatment was dangerous when given to out-patients, he has tried it out in the community and found it is a definitely workable proposition.

Dr. Guy Payne (Superintendent, Essex County Hospital, Cedar Grove): From 1922 to 1938, before we got shock therapy underway, approximately 59 per cent of our insane first admissions were released to the community after a period of treatment at the hospital. From 1938 on, following introduction of the various shock therapies, we have discharged nearly 66 per cent. I must remark, therefore, that we have not lived through a better period than in recent years in the percentage of cases released from the hospitals.

Our doctors are improving the readjustment of cases admitted to our mental hospitals by helping the patients to work out their family relationships better.

Dr. J. Berkeley Gordon (Superintendent, New Jersey State Hospital, Marlboro): One of the problems which face all psychiatrists working in hospitals is that of diagnosis. There is such a difference in the way different psychiatrists diagnose cases with similar clinical pictures that we are not always sure comparisons of our treatment results are authentic. It is my feeling that the probable answer is that there is a change in mental mechanism of different patients as time goes on. In other words, that a manic type of case may change to the clinical picture of a dementia praecox, or vice versa.

In closing, I would say that we have successfully treated some hyperthyroid cases with shock treatment without having encountered the thyroid storms we had anticipated.

T. R. Robie, M.D., Secretary,
N. J. Neuro-Psychiatric Ass'n.

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# PERIOSTEUM FOR HERNIOTOMY *

## PROCEDURE USED FOR DIRECT AND FEMORAL HERNIAS

Eugene V. Parsonnet, M.D.†

The primary reason for failure of repair and recurrence of direct hernia lies in the use of the inguinal ligament. When tension is required to approximate parts, the ligament is weakened and pulled away from its loose posterior attachment and incorporated with one of the superior structures. This difficulty may be avoided, suggests Lt. Comdr. Eugene V. Parsonnet, M.C., U.S.N.R., by using the periosteal covering of the superior ramus of the pubis, which extends laterally and upward from the pubic spine to the ilium.

After exposure of the inguinal canal, isolation of the cards, and treatment of the sac by simple reduction or resection, the periosteal covering is exposed by gauze and finger dissection from the pubic spine to the femoral vessels. Upon exposure of the fascia, the internal oblique muscle is retracted superiorly and medially, and the fascia of the transversus abdominis muscle is exposed by finger retraction of the femoral vessels, laterally. With the hernia depressed, the fascia of the transversus abdominis muscle is sutured to the periosteum. Sutures, picking up the transversalis fascia, are first placed near the femoral vein to avoid trauma to that vessel.

Three interrupted sutures of chromicized No. 1 catgut usually are sufficient, although occasionally a fourth may be necessary. Tying is reserved until all stitches are satisfactorily placed. Ample overlying space is formed in which the cord may be replaced without need of suturing the fascia of the external oblique muscle.

The same procedure for the same basic anatomic consideration is equally as satisfactory in repair of femoral hernia.

* Reprinted from Modern Medicine, Vol. XIII, No. 5, p. 81.
† Parsonnet, E. V., Repair of Direct Hernia. U. S. Nav. M. Bull. 44:507-508, 1945.

# STATE ACTIVITIES

## IRON TABLETS TO RED CROSS BLOOD DONORS

Since the inauguration of the Blood Donor Service to procure blood for military use, certain Centers have been used as "pilot" Centers to investigate methods pertaining to the taking of blood and to observe the effects of the donating of blood on the donors themselves. Early in the program investigators in the Columbus, Ohio; St. Louis, Missouri, and Detroit, Michigan, Centers began a study on the effects of iron on the regeneration of hemoglobin. These studies have now been completed and soon will be published in detailed form, but we would like to bring a few of the conclusions to your attention at this time. First of all, it is apparent that less than one per cent of male donors have a hemoglobin level of lower than 12.3 grams per 100 cc. of blood, which is the threshold level that we have established for both male and female donors. Practically all of the eligible male donors, that is those with hemoglobin above 12.3 grams, regenerate their blood quickly and almost all of these attain their predonation hemoglobin level in four weeks or less. The investigation of female donors, however, showed somewhat different results. Approximately 10 per cent of women in the 18 to 60-year age groups who appear to make their first blood donation must be refused because they have less than the threshold level of 12.3 grams. Furthermore, those with hemoglobin above this level show a considerable variance in the speed of regeneration after a blood donation. Some form new hemoglobin as rapidly as males but most of them take a longer time and a few will not reach their predonation level by the end of 8-10 weeks, at which time they may have made appointments for another donation. It was the two latter groups that we were particularly interested in and it was found that hemoglobinogenesis was measurably and significantly increased by the taking of even as little as 5 grains of iron daily.

We feel that blood donors have an increased demand for iron that can be in a sense compared to the increased demand for iron known to be present in the last trimester of pregnancy. In the latter it is almost universal practice to prescribe iron to maintain iron reserves and it is apparent that many blood donors likewise will benefit by supplemental iron.

Beginning shortly the American Red Cross New York Blood Donor Center will offer to each female donor an envelope containing approximately one hundred 2½ grain tablets of a ferrous salt. No insistence will be made that they take the tablets and they will be given only to women who have just completed a blood donation. Under no circumstance will iron tablets be distributed to anyone who is rejected as a donor because she fails to meet our hemoglobin standard. Objections may be raised by women who have donated previously but they will be, as in the past, referred to their own physicians.

The following is a copy of the inscription on the envelope which the donor receives:

TO BLOOD DONORS

As millions know from experience, healthy adults can donate a pint of blood every eight weeks without impairing their health in any way. The body soon replaces the blood given which is composed principally of fluids, proteins, and red blood cells containing iron. All these are obtained through a normal diet, with the occasional exception of iron.

Recent studies conducted by the Blood Donor Service, however, demonstrate that addition of iron to the diet of women donors usually *speeds* replacement of the red cells, just as salt tablets on a hot summer day speed the replacement of salt lost through perspiration. Accordingly, enough iron tablets to replace the amount of iron in a pint of blood are now being given to donors desiring them.

Those wishing to take them should take one tablet before breakfast the *first* day following the donation; one before breakfast and one before lunch the *second* day; and one before each meal the *third* day and thereafter until all the tablets in this envelope have been used.

Mary Heiss Boynton, M.D.
Physician-in-Charge
Red Cross Blood Donor Service
New York, New York
Henry S. Blake, Lt. (M.C.), U.S.N.R.
National Technical Director
Blood Donor Service
American Red Cross.

# NUTRITION IN EVERYDAY PRACTICE

S. WILLIAM KALB, M.D., Newark, N. J.

Nutrition Representative, Tuberculosis and Adult Disease Control Advisory Committee to the Subcommittee on Public Health

## TIME REQUIRED FOR FOOD TO PASS THROUGH THE STOMACH

To satisfy many questions on digestion and on eating before bedtime, the following table demonstrates the length of time food remains in the stomach. It will be observed that foods rich in fats or proteins require a much longer digestion time than foods which are rich in sugars or starches.

| FOOD | PORTION | HOURS | MINUTES |
|---|---|---|---|
| Fruits | 1 portion | 2 | 20 |
| Vegetables, cooked | 2 tablesp. | 2 | 15 |
| Milk | 1 glass | 2 | 30 |
| Bread | 1 slice | 2 | 40 |
| Cereals | 1 portion | 2 | 40 |
| Pie | 1 portion | 2 | 30 |
| Cakes | 1 small piece | 3 | 00 |
| Puddings | 1 portion | 2 | 20 |
| Sugar and Candies | 1 piece | 2 | 05 |
| Ices | 1 dip | 2 | 35 |
| Ice Cream | 1 dip | 3 | 15 |
| Eggs, soft boiled | 2 | 1 | 45 |
| Eggs, raw | 2 | 2 | 15 |
| Eggs, poached | 2 | 2 | 30 |
| Eggs, hard boiled | 2 | 3 | 00 |
| Egg Omelet | 2 | 3 | 00 |
| Fish, baked | 1 portion | 2 | 50 |
| Fish, fried | 1 portion | 3 | 15 |
| Beef Juice | 4 oz. | 2 | 00 |
| Beef, boiled | ¼ lb. | 3 | 00 |
| Steak | ¼ lb. | 4 | 00 |
| Roast Beef | ¼ lb. | 4 | 00 |
| Roast Veal | ¼ lb. | 4 | 15 |
| Ham, boiled | ¼ lb. | 3 | 30 |
| Roast Pork | ¼ lb. | 4 | 00 |
| Pork Chops, broiled | 1 chop | 2 | 45 |
| Pork Chops, fried | 1 chop | 5 | 00 |
| Lamb, roast | ¼ lb. | 3 | 45 |
| Lamb Chops, broiled | 1 chop | 2 | 35 |
| Lamb Chops, fried | 1 chop | 5 | 00 |
| Chicken, boiled | ¼ lb. | 2 | 45 |
| Chicken, roast | ¼ lb. | 4 | 15 |
| Chicken, fried | ¼ lb. | 5 | 00 |
| Turkey, roast | ¼ lb. | 4 | 00 |
| Pigeon, roast | ¼ lb. | 3 | 45 |
| Duck, roast | ¼ lb. | 5 | 00 |
| Goose, roast | ¼ lb. | 4 | 30 |
| Tongue, smoked | ¼ lb. | 4 | 15 |
| Frankfurter | 1 frank | 3 | 45 |
| Bologna | ¼ lb. | 4 | 00 |
| Salami | ¼ lb. | 5 | 00 |

# STATE BOARD OF MEDICAL EXAMINERS

E. S. HALLINGER, M.D., Secretary

Following is a report of the activities of the Board in enforcing the Medical Practice Act:

February 14, 1945, the license to practice medicine and surgery of Stephen A. Leslie, M.D., of New York City, was revoked by the Board on a charge of conviction of the crime of criminal abortion.

February 14, 1945, the Board restored the license to practice medicine and surgery of Louis G. D'Elia, M.D., of Secaucus, New Jersey, which was revoked on October 10, 1943. .

March 7, 1945, Earl E. Kailey of Trenton, an unlicensed chiropractor, paid a penalty for practicing medicine without a license. This was a fourth violation.

March 7, 1945, Steven C. Sarchio of Passaic, an unlicensed chiropractor, paid a penalty for practicing medicine without a license. He gave adjustments, electric treatments and herbs.

March 7, 1945, Felix A. Lisena of Newark, an unlicensed chiropractor, paid a penalty for practicing medicine without a license. He took x-rays, gave adjustments, used an electric vibrator and gave medicine. This was a second violation.

March 7, 1945, Gertrude Hamilton of Paterson, an unlicensed chiropractor, paid a penalty for practicing medicine without a license. She gave adjustments, electric treatments and herbs. This was a second violation.

March 7, 1945, Randal J. Brown of Trenton, a registered pharmacist, paid a penalty for practicing medicine without a license. This is the ninth time he has paid a penalty.

April 11, 1945, the matter of the revocation or suspension of the license to practice medicine and surgery of Joseph L. Polizzotti, M.D., of Paterson was discontinued by the Board.

April 26, 1945, Ida Scharfegger of Jersey City was tried before Judge Sewell of the First District Court of Jersey City on a charge of practicing medicine without a license and a decision rendered in favor of the defendant. Mrs. Scharfegger gave massage, electric treatments and colonic irrigations. This was the second case against her.

May 8, 1945, William J. Jemison of Asbury Park, an unlicensed chiropractor, paid a penalty for practicing medicine without a license. This was a second violation.

May 10, 1945, James A. Mackey of Trenton, an unlicensed chiropractor, was tried before Judge Pellettieri of the First District Court of Trenton, and found guilty on a charge of practicing medicine without a license. This was the third case against Mackey. He gave adjustments, took blood tests and ordered anabolic foods.

May 22, 1945, George H. Earp-Thomas of Bloomfield was tried before Judge MacMahon of the First

District Court of Newark, and found guilty on a charge of practicing medicine without a license. This was a second offense. He used the title "Dr.", and prescribed minerals and cultures which he prepared in his own laboratories.

June 19, 1945, Minnie Black of East Orange, a licensed chiropractor, was tried before Judge MacMahon of the First District Court of Newark, and found guilty on a charge of practicing medicine without a license. This was a second offense. She exceeded her chiropractic license by practicing iridology, using an electric vibrator and prescribing medicine.

June 28, 1945, Judge MacMahon of the First District Court of Newark, rendered a decision in favor of the Board in the case against Stanley J. Bayorek of Irvington, who was tried June 19, 1945, on a charge of practicing medicine without a license. This was a second offense.

July 2, 1945, Judge Hinchcliffe of the First District Court of Paterson rendered a decision in favor of Frank Vermeulen, an unlicensed chiropractor, who was tried on February 1, 1945, on a charge of practicing medicine without a license. This was the fifth case against Vermeulen. He gave adjustments, ordered cold baths and used a foot oscillator.

July 10, 1945, Oscar P. Mallard of Vineland, a registered pharmacist, paid a penalty for practicing medicine without a license.

July 10, 1945, George B. Van Dyke of Trenton, an unlicensed chiropractor, paid a penalty for practicing medicine without a license. This was the second case against Van Dyke. He gave electric treatments, adjustments and ordered medicine.

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## WITH NEW JERSEY MEDICAL AUTHORS

Compiled by MILDRED V. NAYLOR, Librarian, Academy of Medicine

It is requested that any New Jersey physician who publishes an article outside the state, notify the Editorial Office in Trenton, giving the title of the paper and the name of the periodical, as well as the month, date, volume and page number. It would also be helpful to this office if members would notify us of articles published by their colleagues.

BRIGGS, HENRY, and JACOB KRAUSE—East Orange
Intervertebral foraminotomy for relief of sciatic pain. J. Bone & Joint Surg. 27: 475-478, July 1945

CLEMENT, BAXTER L.—Newark (now in service)
Fracture-dislocation of the base of the fifth metacarpal. J. Bone & Joint Surg. 27: 498-499, July 1945

CUONO, JOSEPH D.—Paterson (now in service)
Meckel's diverticulum; report of a case. U. S. Nav. M. Bull. 45: 339-341, Aug. 1945

DONOVICK, RICHARD, Ph.D.—see Rake, Geoffrey

EISENSTODT, LESTER W.—Newark
Skin grafting in moribund burned patients. Am. J. Surg. 69: 168-173, Aug. 1945

GNASSI, ANGELO M., and PRESTON PRICE—Jersey City
Malignant giant cell tumor of the lung. Am. J. Roentg. 53: 582-584, June 1945

HAMRE, DOROTHY, Ph.D.—see Rake, Geoffrey

HULETT, A. G.—East Orange (now in service), with LT. COL. HERMAN RUBIN
An unusual carrier state. Am. J. Clin. Path. 15: 152-153, April 1945

KAVANAUGH, DOROTHY, Ph.D.—see Rake Geoffrey

KENNEY, JOHN A.—Montclair
Plea for interracial coöperation. J. Natl. M. A. 37: 121-124, July 1945

KOERBER, WALTER L., Ph.D.—see Rake, Geoffrey

KRAUSE, JACOB—see Briggs, Henry

LARSEN, ALMA—see Stokes, J. L.

MACART, JAMES H.—South Orange (now in service)
Care of wounded in a light cruiser being a discourse on the medical strategy in handling 426 casualties from explosion. Hosp. Corps Quart. 18: 70-74, July 1945

MATHESHEIMER, J. L.—Jersey City
An ambulant method for the treatment of pilonidal disease. Am. J. Surg. 69: 230-231, Aug. 1945

OLPP, JOHN L.—Englewood (now in service), with I. WM. NACLAS
Para-articular calcification (Pellegrini-Stieda) in affections of the knee. Surg., Gynec. & Obst. 81: 206-212, Aug. 1945

PARKES, MOREY—Caldwell (Curtiss-Wright)
Use of paraprol in the prevention of industrial dermatitis; preliminary report. Indust. Med. 14: 565-566, July 1945

PIRK, LEO A., Ph.D.—Nutley (with R. Engelberg)
Action of quinine sulfate. J. A. M. A. 128: 1093-1095, Aug 11, 1945

PRICE, PRESTON—see Gnassi, Angelo M.

RAKE, GEOFFREY; DOROTHY HAMRE, FREDERICK KAVANAUGH, WALTER L. KOERBER and RICHARD DONOVICK—New Brunswick
On the toxicity of streptothricin. Am. J. Med. Sci. 210: 61-66, July 1945

STOKES, J. L., and ALMA LARSEN—Rahway (Merck & Co.)
Amino acid requirements of acetobacter suboxydans. J. Bact. 49: 495-501, May 1945

TAYLOR, JOHN H.—Trenton
Involutional psychoses treated with shock therapy. Dis. Nerv. Syst. 6: June 1945

WATERS, EDWARD G.—Jersey City
Use and abuse of cesarean section. Am. J. Surg. 69: 208-212, Aug. 1945

## OBITUARY

### DR. GEORGE A. HARROP, JR.

Dr. George A. Harrop, Jr., of Princeton died on August 4, 1945, at Columbia Medical Centre, New York City, following a long illness.

Dr. Harrop was born in 1891. He was graduated from Harvard University in 1912, and later attended Johns Hopkins Medical School, receiving his medical degree in 1916. Following his graduation, he was Associate Professor of Medicine at Johns Hopkins Hospital. For the past eight years he served as Director of the Squibb Institute for Medical Research, New Brunswick. He was also Vice-President of E. R. Squibb and Sons, New York City.

Dr. Harrop was a frequent contributor of articles to medical journals and held membership in the Mercer County Medical Society, The Medical Society of New Jersey and American Medical Association.

## BOOKS RECEIVED FOR REVIEW

CLINICAL TRAUMATIC SURGERY. By John J. Moorhead, B.S., M.D., D.Sc., F.A.C.S. (D.S.M.). Pp. 747 with 500 illustrations. Philadelphia & London, W. B. Saunders Co. 1945. $10.00.

MANUAL OF SURGICAL ANATOMY. Prepared under the auspices of the Committee on Surgery of the Division of Medical Sciences of the National Research Council. By Tom Jones and W. C. Shepard. Pp. 195 with 267 illustrations, on 138 figures, 153 in color. Philadelphia & London, W. B. Saunders & Co. 1945. $5.00.

FACIAL PROSTHESIS. By Arthur H. Bulbulian, M.S., D.D.S., F.A.C.D. Pp. 241, with 202 illustrations. Philadelphia & London, W. B. Saunders & Co. 1945. $5.00.

CLINICAL BIOCHEMISTRY. By Abraham Cantarow, M.D., and Max Trumper, Ph.D. 3d ed. Pp. 647 with 29 illustrations. Philadelphia & London, W. B. Saunders & Co. 1945. $6.50.

BACILLARY DYSENTERY, COLITIS AND ENTERITIS. By Joseph Felsen, B.A., M.D. Pp. 618 with 145 illustrations. Philadelphia & London, W. B. Saunders Co. 1945. $6.00.

## BOOK REVIEWS

**Nervousness, Indigestion, and Pain.** By Walter C. Alvarez, M.D. Pp. 488. New York, Hoeber, Medical Book Department of Harper & Bros. 1943. $5.00.

The author's former *Nervous Indigestion* is now a fuller volume, greatly enriched by his latest clinical experience. Dealing with humans whose personality disorders are so closely tied in with a gastrointestinal complaint has for a long time made the author always a shrewd observer, with keen and sympathetic insight, a kind of practical psychiatrist. Indeed, his handling of the first portion of the book dealing with history and examination, and diagnosis and handling of the nervous patient, are chapters which might well be read by all who practice medicine. They are full of understanding and tell in the author's own chatty way much that is fine and useful in dealing with those humans, our patients, who need to tell their full stories. Alvarez points out the need for psychiatric insight; so much needed by all practitioners and specialists, too.

There is, in this reviewer's mind, the notion that too much emphasis on heredity is made. Another criticism is that too often the words "crazy", "insane", and other similar terms appear in rather broad form. The subject matter of the book will appeal to many lay persons and for this reason it would perhaps be better if in a future edition some of this material could be toned down, and edited in such a manner as to even make the book more useful for the intelligent layman, too.

This valuable book not only is well printed and easiy read, but holds so many clinically useful suggestions, that it should serve in the further development in the study of psychosomatic factors in human illnesses. It appears to this reviewer at least that the few criticisms from the psychiatric standpoint which might be made should in no way deter from the effectiveness and the really valuable purpose that this book should serve. It is no doubt being well received by lay and medical readers alike.

CHARLES ENGLANDER, M.D.

**Chemical Formulary:** A Collection of Valuable, Timely, Practical Commerical Formulae and Recipes for Making Thousands of Products in Many Fields of Industry. By H. Bennett, Editor-in-Chief. v. 7. Pp. 474. Brooklyn, N. Y., Chemical Publishing Company, Inc. 1945. $6.00.

This book admirably fulfills the objectives indicated in its subtitle. One could, indeed, extend the latter by adding that many of the products and processes described can be readily adapted to the needs of the farmer, gardener, home owner, housewife, and of amateurs subscribing to various interests such as photography, carpentry, the making of art objects, and numerous other pursuits. The wide

scope of the book naturally limits the extent to which the individual specialties are covered; in fact, exhaustive consideration of special fields is obviously not the object of the Formulary.

One could wish that greater attention had been paid to some subjects; as, for instance, the blending of paints, or to some of the newer enteric tablet coatings, and annual feeds.

The book, like the others of the series, is well indexed, and an excellent handy reference for the industrial or home library. S. WIEDER.

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**Penicillin and Other Antibiotic Agents.** By Wallace E. Herrell, M.D., M.S., F.A.C.P. Pp. 348, illustrated. Philadelphia & London, W. B. Saunders Company. 1945. $5.00.

A review of the literature on penicillin, tyrothricin, streptothricin, streptomycin and other antibiotic agents is compiled in this book in an interesting manner, with the author's interpretations of the value of these agents in the treatment of various conditions and the methods and regimens of administration. In some places the author relates his own experience with these therapeutic agents.

The book is well planned and organized. Part I deals with the history, preparation, physical and chemical properties, antibacterial activity, absorption and distribution, excretion and methods of testing for penicillin. Part II deals with choice of preparations, synergistic action, methods of administration and general effectiveness when used against diseases of certain systems, such as the blood streams and heart, the central nervous system, the respiratory system, etc. In Part III the consideration of the clinical use of penicillin is continued, with particular reference to its effectiveness against specific diseases and with reference to the toxicity of the drug. Part IV consists of a review of the antibiotic agents other than penicillin.

This is a thoroughly practical book for the practitioner of medicine. The personal observations and opinions are those of a man who is well qualified to make them. There are a few good photographs of the before and after type and the charts and tables are effective and easily understood. Extensive references to the literature are given and the book is well indexed.

This book is recommended.

GLENN S. USHER, M.D.

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**Hay Fever Plants:** Their Appearance, Distribution, Time of Flowering, and their Rôle in Hay Fever, with special reference to North America. By Roger P. Wodehouse, Ph.D. Pp. 245, illustrated. Waltham, Mass., The Chronica Botanica Co., New York, G. E. Stechert & Co. 1945. $4.75.

All the plants causing, or suspected of causing, hay fever by their pollens, are brought together for the first time in one volume in this valuable monograph. The arrangement is botanical, following the sequence of Engler and Prantl. The plants described fall into two classes, the gynosperms, relatively few, and the angiosperms, which form the great group of allergic plants. Botanical and common names are used in the descriptions which are well written and sufficient for their purpose, including the physical characteristics, distribution, time of flowering and the part the plants play in the causation of hay fever. The numerous illustrations of flowers and pollens should prove useful for identification purposes.

The work is divided into two main parts: the first discusses pollen and pollination and the rôle of pollen in hay fever. The second part consists of a series of regional surveys covering the United States by areas, also Canada and Mexico. The United States is divided into ten regions and only the noxious plants are described for each region.

An interesting short chapter on the botany of hay fever, in which atmospheric pollen is considered, is found at the beginning of the book and a selected bibliography is appended to the text. The book is well written with a good type, on nonglare paper, and good margins.

This monograph is recommended to all physicians coming into contact with allergic disturbances, as well as for all medical, public and reference libraries. JAMES F. BALLARD.

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**Management of Neurosyphilis.** By Bernhard Dattner, M.D., Jur.D., with the collaboration of Evan W. Thomas, M.D., and Gertrude Wexler, M.D. Foreword by Joseph Earle Moore, M.D. Pp. 398. New York, Grune & Stratton. 1944. $5.50.

This extremely important volume, an outgrowth of the author's 1933 monograph on the same subject, is full of meaty experience, keen knowledge and sound views concerning the many problems in diagnosis and treatment of neurosyphilis. His main thesis is that all who treat patients with neurosyphilis, should be thoroughly familiar with the spinal fluid changes and their significance. He wisely points out the error of depending upon physical examination findings alone.

A large portion of the work is devoted to laboratory procedures. One could do with less of this in so important a work and prefer that the closely printed pages be otherwise used for the benefit of the reader. This latter defect in the set-up of the volume makes it more difficult to read and detracts somewhat from its effectiveness. A book to be useful, should be practical in the availability of its material. There are so many useful and interesting subjects in this otherwise outstanding volume, one hardly knows to which to devote review space. Of particular value are the portions which deal with the physical aspects and the significance of spinal fluid changes. On this subject the author is unquestionably on firm ground. The portions on spinal fluid syndromes and therapeutic malaria, which the author still prefers and with which this reviewer agrees, are particularly well written. The chapters on methods and applications and results of various therapeutic methods are also particularly good.

The bibliography is good and the index fine. This fine work is recommended to all who treat patients who have neurosyphilis, or for that matter, syphilis in any form, and it should be in every hospital and laboratory library. CHARLES ENGLANDER, M.D.

# WOMAN'S AUXILIARY

## PRESIDENT'S MESSAGE

Mrs. William E. Dodd

The day we have hoped and prayed for has arrived. V-J Day has officially been acclaimed. To the many members of the Medical Corps who served so valiantly we are indebted for their meritorious work. To those who so bravely gave their lives the Woman's Auxiliary to The Medical Society of New Jersey pays undying tribute. The Victory is won; Peace is yet to be secured.

"Looking Ahead," we see V-M Day a little closer. A day which will be very much discussed and one which may not come unless the united efforts of the Medical Society and Auxiliary provide a workable plan for the future.

The Medical-Surgical Plan of New Jersey, organized by The Medical Society of New Jersey, deserves special attention as it is one of the most workable plans of prepaid medical care. According to Norman M. Scott, M.D., Executive Vice-President, "One of the most stimulating and encouraging phases of our work in New Jersey is the constantly increasing demand from other State Societies for information and advice based upon our experience in developing the medical care distribution program of The Medical Society of New Jersey."

During this coming year the most important work assigned to Auxiliary members is to keep lay groups continuously informed about the work organized medicine is doing in the interests of the people of this state. This will not prove to be an "A" bomb but it is a weapon deserving great consideration.

In the near future many of our doctors in the Armed Service will return to civilian practice. Let us be helpful in solving the problems confronting them and welcome their return.

With the lifting of gas rationing greater attendance at Auxiliary meetings is to be expected. Those Auxiliaries which curtailed the number of meetings per year are earnestly requested to return to their former schedules. With the lessening of Red Cross activities there will be more time available to devote to Auxiliary matters.

A warm welcome is extended to each member to attend the Fall Board Meeting in Trenton on October 8, 1945.

## PUBLICITY

Through the courtesy of the Publication Committee of The Medical Society of New Jersey these pages have been allotted to us.

Herein we may record our great or small activities, our progress, our aims and achievements.

Those of us who bring you this section would have each member remember that these are Auxiliary pages and that the content thereon depends on the interest of the entire membership.

## AUXILIARY REPORT

### Atlantic County

Mrs. Samuel Salasin, Chairman of Publicity

Mrs. Robert A. Bradley, newly elected President of the *Woman's Auxiliary to the Atlantic County Medical Society*, entertained the members of the Board of the Auxiliary at a delightful luncheon in the Mirror Room of the Shelburne Hotel, Saturday, July 14, 1945.

Mrs. Bradley welcomed the guests and asked for their coöperation throughout the coming year.

Mrs. Bradley and the Program Chairman, Mrs. Ruffin G. Stamps, formulated the plans for the monthly meetings. The first meeting, a special luncheon, will be given in honor of the new State President, Mrs. William Dodd of Beach Haven, N. J., in October. Mrs. Louis Feinstein and Mrs. Herman Kline will be co-chairmen of the event.

Mrs. Anthony Merendino, Chairman of the Ways and Means Committee, will hold a cocktail party in the near future for the Welfare Fund. Final arrangements will be announced later.

The following standing committees gave reports: War Participation, Mrs. Herman Kline; Ways and Means, Mrs. Anthony Merendino; Camp and Hospital, Mrs. David B. Allman; Student Nurse Fund, Mrs. Lawrence Wilson; Arts and Hobbies and Medical History, Mrs. James Mason III; Bulletin, Mrs. Earl Johnson; Cheer Chairman, Mrs. Baxter Timberlake; Public Relations, Mrs. David B. Allman; Press and Publicity, Mrs. Samuel L. Salasin, and Hygeia, Mrs. Bernard Crane.

# TUBERCULOSIS ABSTRACTS

*A Review for Physicians*

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

**Vol. XVIII** **September, 1945** **No. 9**

ANY evidence which helps to answer the question of whether or not an individual under treatment for tuberculosis is a source of danger to others is of vital value to the physician, the patient and the public. The examination of gastric contents for the presence of tubercle bacilli is rapidly becoming an essential procedure in those cases in which other tests fail to give a clear-cut answer.

## TUBERCLE BACILLI IN GASTRIC CONTENTS

Examination of gastric contents for tubercle bacilli in the fasting patient, while a routine procedure among children at Muirdale Sanatorium since its inception, has only gradually been extended to adults. The now demonstrated importance of the procedure in aiding diagnosis, in guiding therapy, and in the evaluation of the patient before discharge has come to be recognized rather slowly.

Examination of gastric contents for tubercle bacilli is used by the author on all patients who deny raising sputum or whose sputum is negative. It is also used in cases where there is doubt as to the source of the sample presented. Since a single negative gastric aspiration is not considered conclusive, repeated aspirations are performed at intervals. Some patients have cultures of both sputum and gastric contents. Such a procedure expedites the diagnosis of cases with suspected active lesions.

The material used for examination consists of undiluted gastric contents aspirated from fasting patients the first thing in the morning. Previous to 1941, culture and guinea pig inoculation were done simultaneously on all specimens. Since that time only cultures are used since they are very accurate and the difference in the results of the two procedures did not warrant continued use of the guinea pig. All specimens are cultured on three slants of Petragnani's medium, and contamination is reported when all three tubes are involved, an infrequent occurrence.

One cannot rely on smears of concentrated specimens of gastric contents for the detection of tubercle bacilli—the number of positives is always small. In certain diagnostic cases animal inoculations, in addition to cultures, are necessary.

The patient who has negative sputum cultures, but who has tubercle bacilli only by gastric examination, is not a so-called innocuous patient. In our survey we observed 21 such patients who on subsequent sputum examination were positive on concentrated smear or culture. Therefore, these patients can and do develop subsequent positive sputum. A patient with a positive gastric content should be treated exactly like a patient with a positive sputum.

Before the author's patients are discharged it is necessary that they have negative gastric aspirations in the absence of sputum. This is done to avoid the discharge of active cases. In order for a patient to be discharged with medical advice as inactive he must have at least five successive negative examinations. If negative on those examinations, and if other findings warrant it, the patient is discharged as having no evidence of active disease.

During the past five years, 868 adults at Muirdale Sanatorium had a total of 4,204 examinations of gastric contents. Of these, 404 (46.4 per cent) had negative gastric contents; they received 1,338 examinations. The remaining 464 (53.6 per cent) cases had 2,866 examinations, of which 1,271 (44.3 per cent) were positive. The number of examinations per case varied, the average for the negative group being 3.3; for the positive group 6.2 per case. The number of repeats depends upon the individual case, just as in sputum examinations.

Thus there are two groups of patients—those

with positive and those with negative gastric contents. Each of these groups in turn is divided into three subgroups: The no-sputum group, the negative-sputum group, and the positive-sputum group.

No fine line of distinction can be drawn between these three subgroups. Occasionally patients deny raising sputum and yet the specimen they send in contains tubercle bacilli. Also, there are patients who state they raise sputum, when the sample is only saliva, or secretions from a chronic nasopharyngitis common in the locality. It is realized that, if numerous and timely sputum examinations were done, a small percentage would have proved positive. This is not deemed economically advisable, as valuable time may be lost. Instead, a simple reliable gastric aspiration can be done with culture results known in a few weeks.

Significantly, 21 out of 282 patients (7.5 per cent) became sputum-positive after being positive at first only on gastric aspiration. This occurred on the average of about six months later. This small group of patients reveals an important fact because, as has been previously pointed out, these cases cannot be considered as harmless, and careful observation and timely sputum examinations will find that some of these cases are sputum-positive.

It is important to do consecutive gastric examinations on adult patients in whom it is impossible to determine the status of activity from a roentgenogram and in whom the sputum, if present, is negative. If five consecutive aspirations are negative on culture, it is most likely that there is no evidence of active pulmonary tuberculosis.

Of the 404 patients in our series who never had a positive gastric aspiration there were 224 who had either no sputum or negative sputum. In spite of the diagnosis of pulmonary tuberculosis on admission the author feels justified in recording a case as having no evidence of active tuberculosis if a series of gastric aspirations is negative as well as sputum cultures.

The remaining 180 of the 404 with negative gastric contents had, at some time, tubercle bacilli in the sputum. The main reason that there were no positive aspirations in this group is because, in most of these patients, the examinations followed by some ten months a positive sputum, and many of these cases were on the road to recovery.

It is possible, however, to have a negative gastric content and a positive sputum, which does not invalidate the reliability of this procedure. There were several patients who became gastric-content-negative and sputum-negative and then later became sputum-positive. Unstable cases of tuberculosis are likely to fluctuate like this.

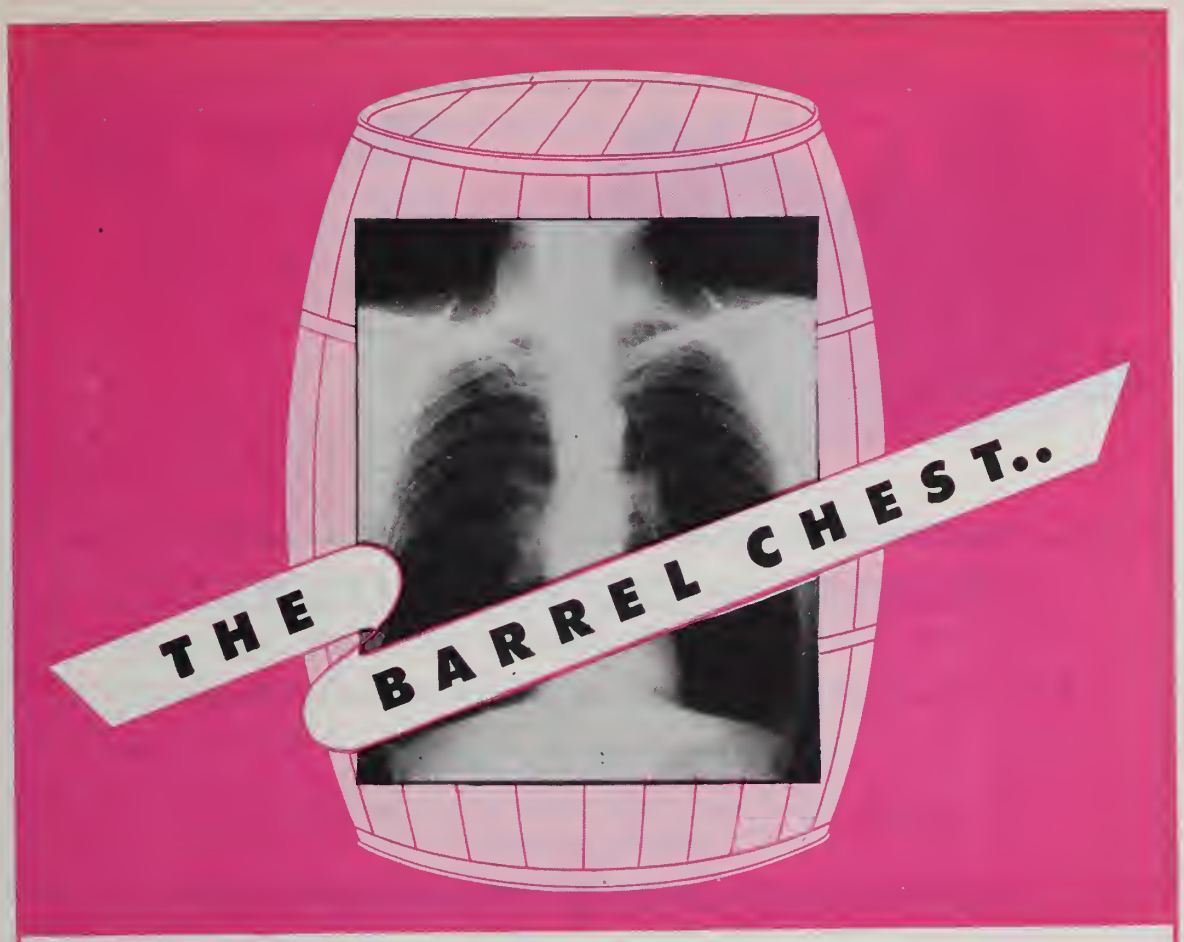
In the past year and one-half it has been the author's policy to do five consecutive aspirations on negative cases. If these examinations are negative by culture, the individual is considered as having no evidence of active pulmonary tuberculosis. In the majority of cases it is wise to hold these patients for observation until the cultures are completed. Of the cultures, over 95 per cent, where positive, will show growth within six weeks. However, the cultures are kept until eight weeks. The patient is then re-X-rayed and his case is re-evaluated. Most of these are discharged with no clinical evidence of active tuberculosis.

*The Significance of Tubercle Bacilli in Gastric Contents, David D. Feld, M.D., The American Review of Tuberculosis, December, 1944.*

SUPPLIED BY

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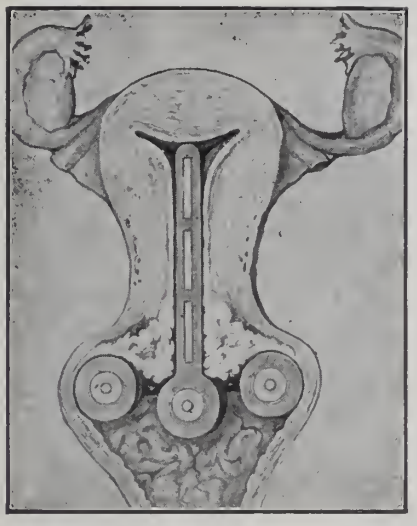
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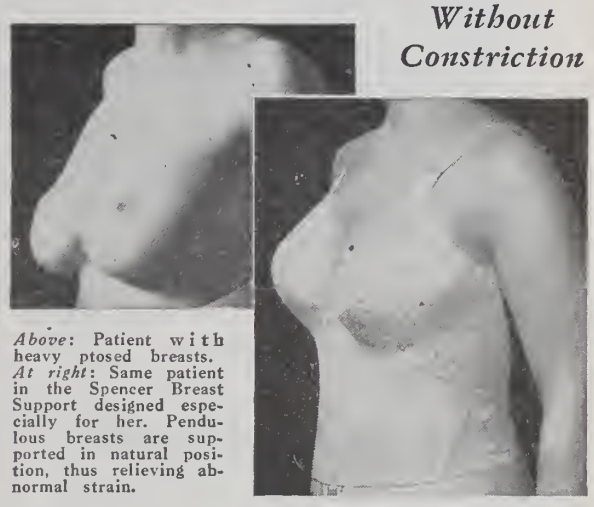
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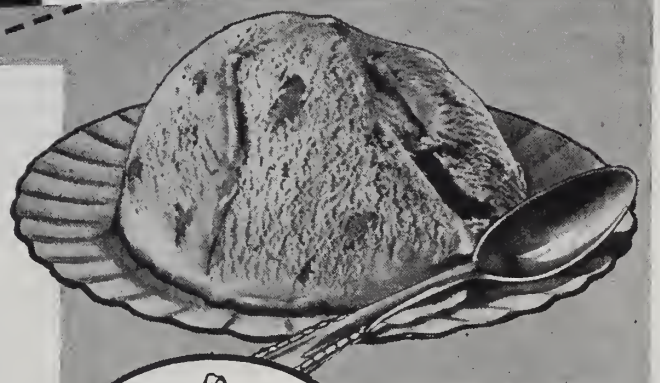
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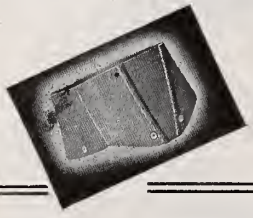
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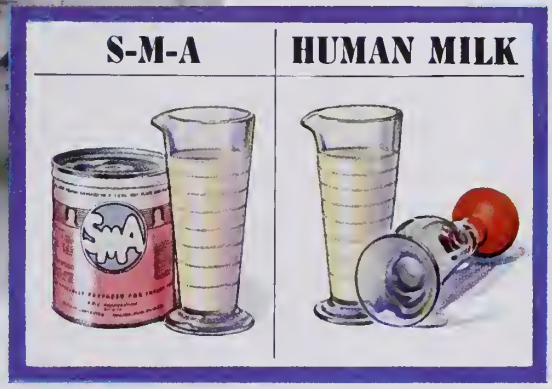
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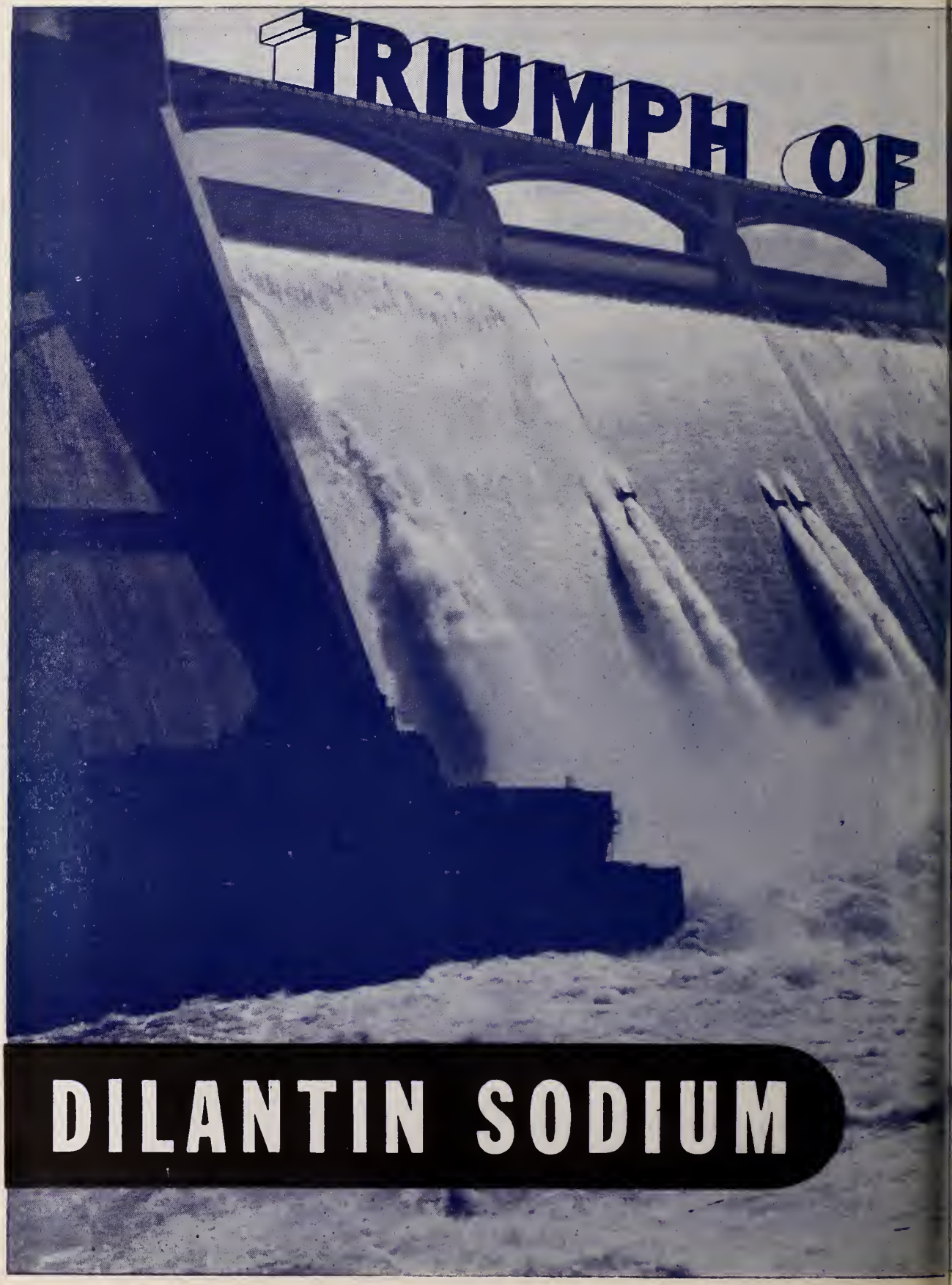
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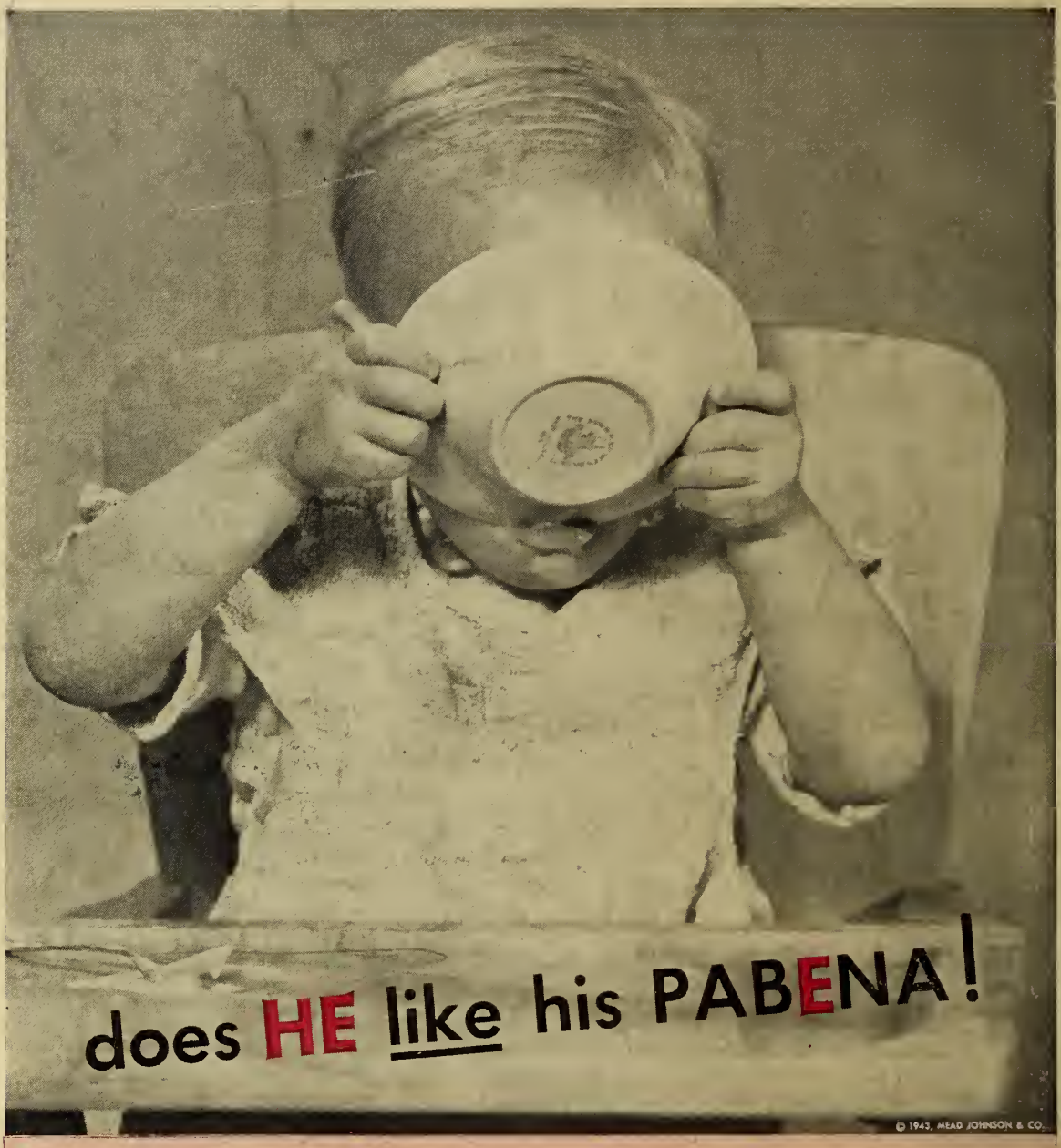

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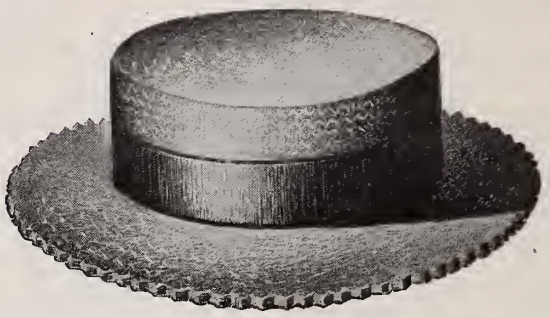
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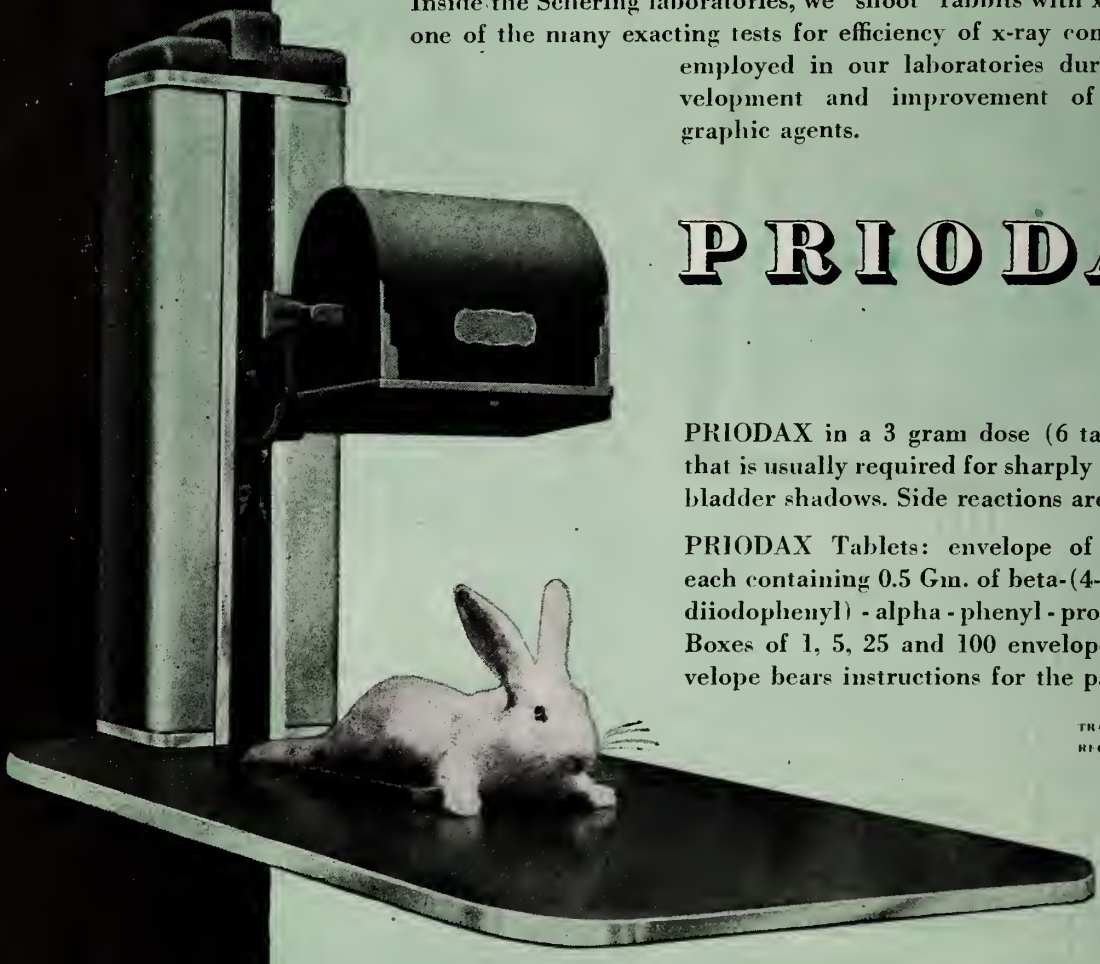
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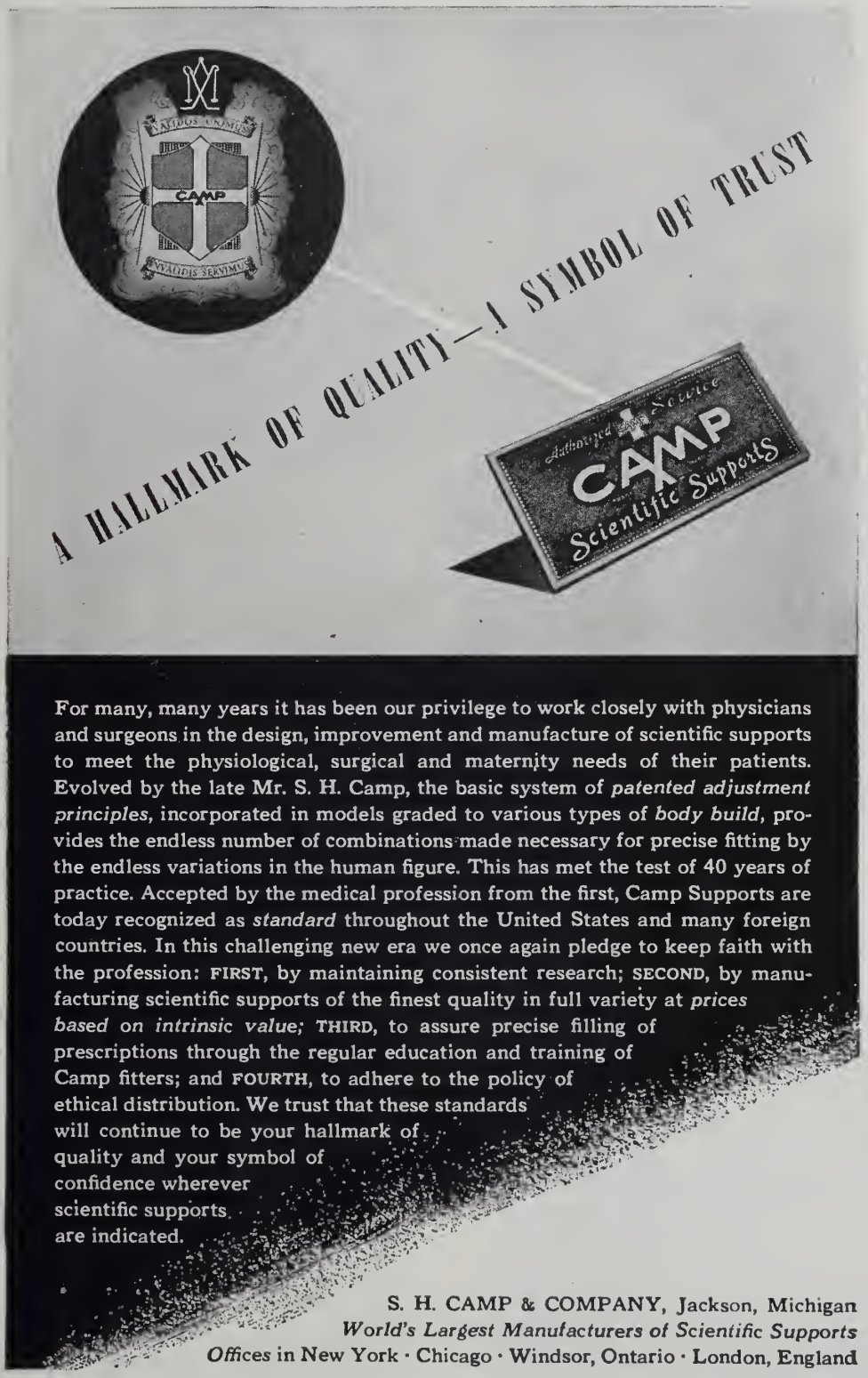
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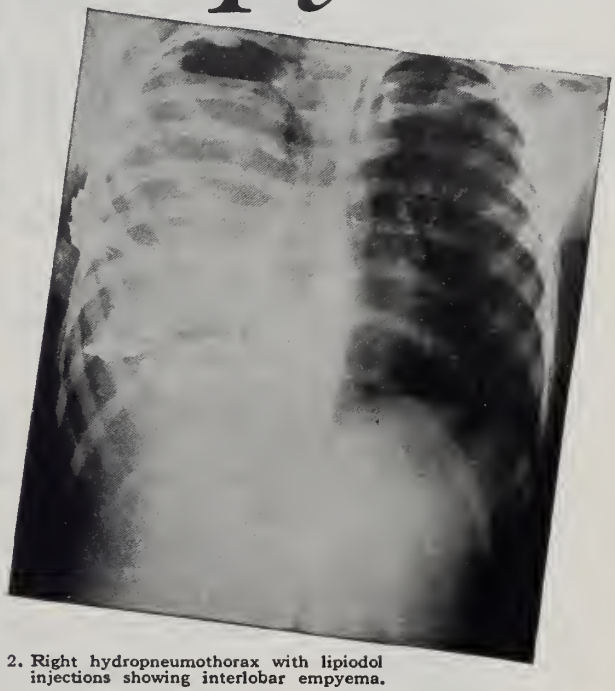
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1. Am. J. Dis. Child. *66*:1 (July) 1943.
2. Nebraska State Med. J. *29*:15 (Jan.) 1940.

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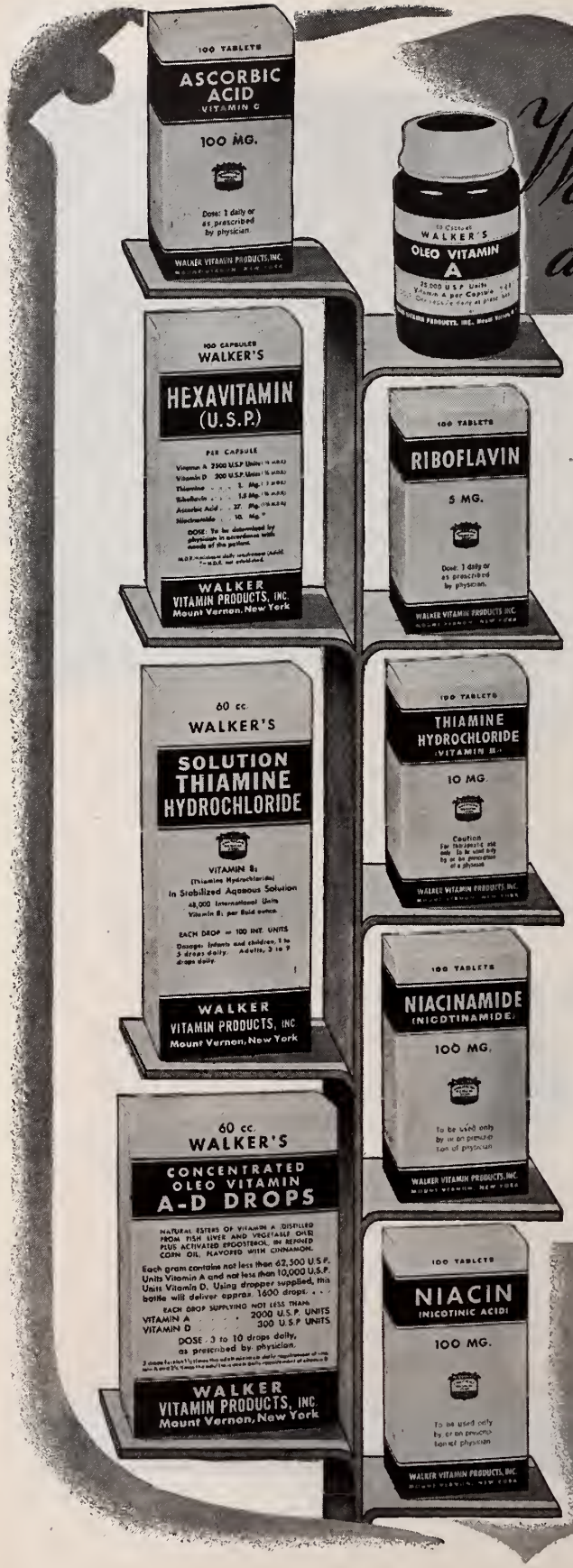
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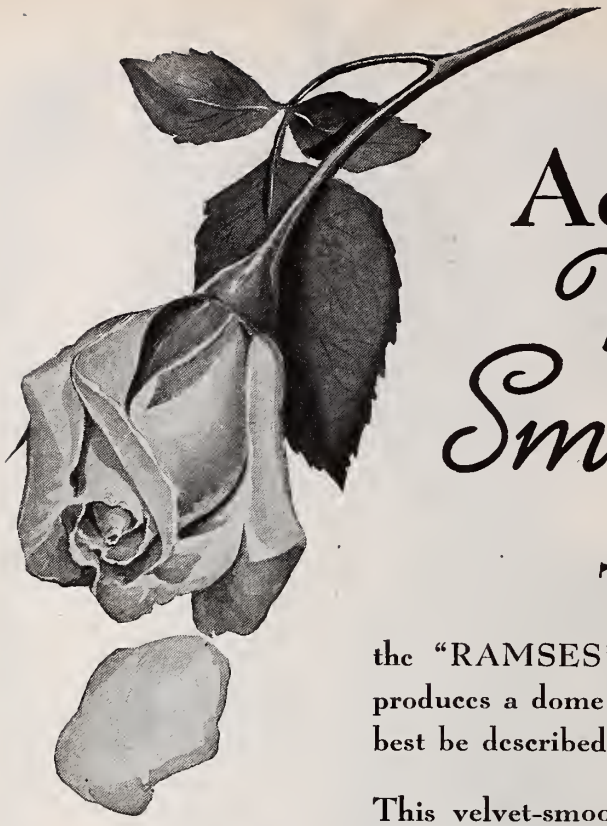
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Salinger, S.: Arch. Otolaryng. 4:40, 324, noting Box, H.E.H.: M. J. Australia 2:126.

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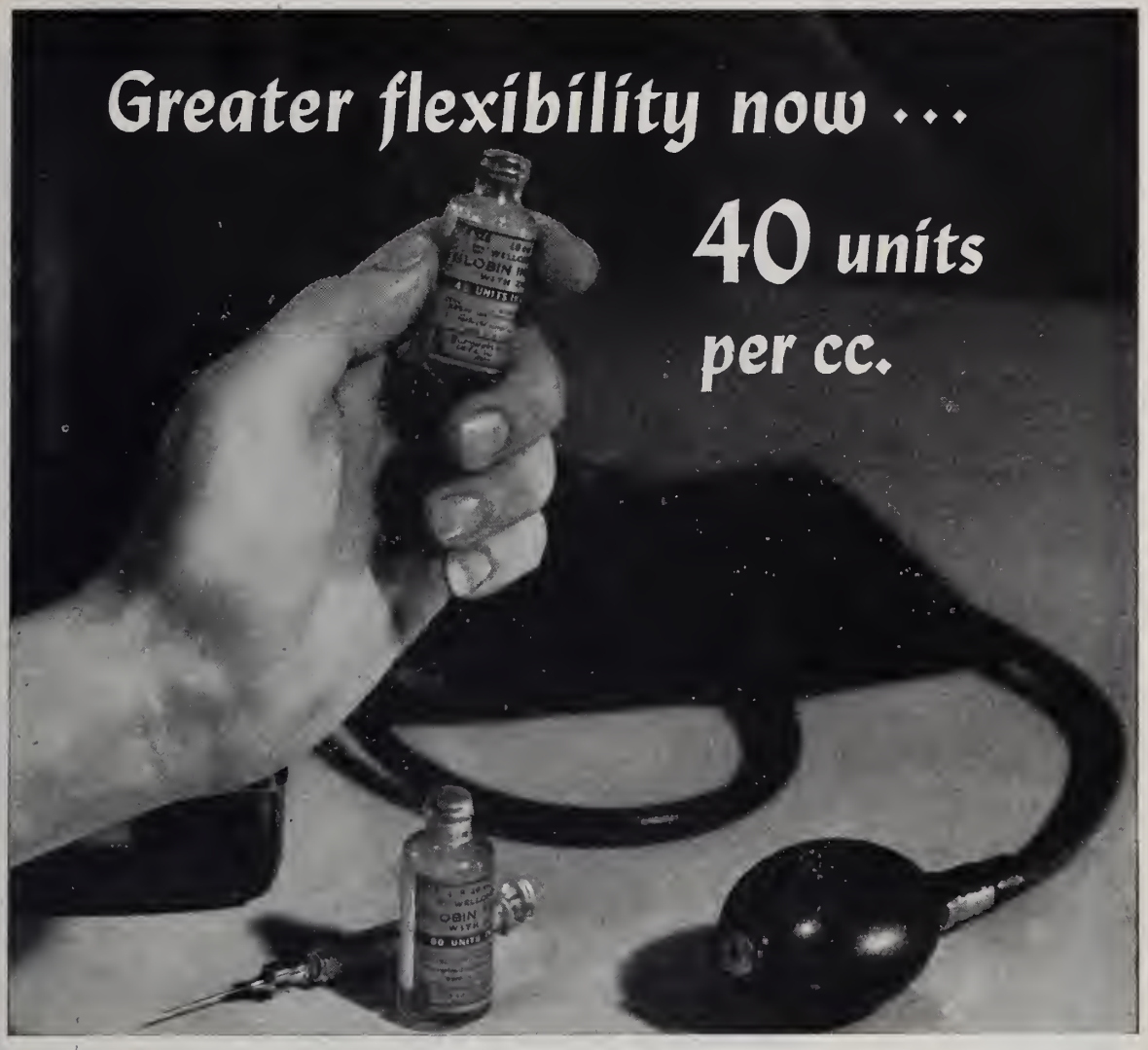
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*Larsen, N. P.: Observations with Penicillin, Hawaii M. J. 3:372 (July) 1944.

Stainsby, W. J.; Foss, H. L., and Drumheller, J. F.: Clinical Experiences with Penicillin, Pennsylvania M. J. 48:119 (Nov.) 1944.

Lockwood, S. J.; White, W. L., and Murphy, F. D.: The Use of Penicillin in Surgical Infections, Ann. Surg. 120:311 (Sept.) 1944.

Kenney, J. F.: Report of a Case of Staphylococcus Bacteremia Treated with Sulfadiazine and Penicillin, Rhode Island M. J. 27:663 (Dec.) 1944.

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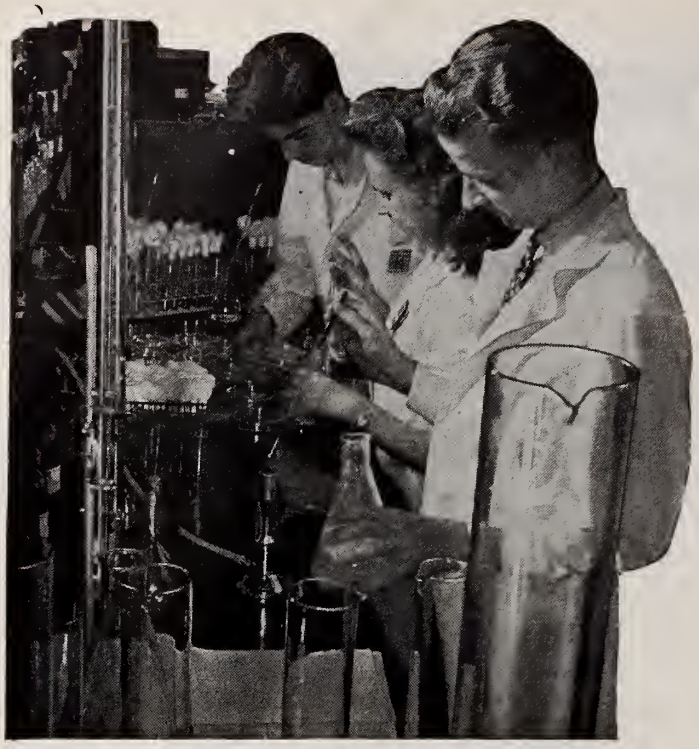
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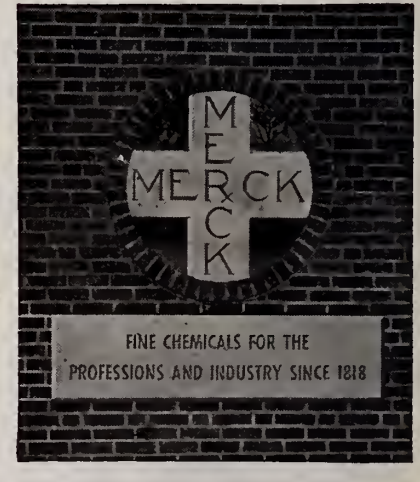
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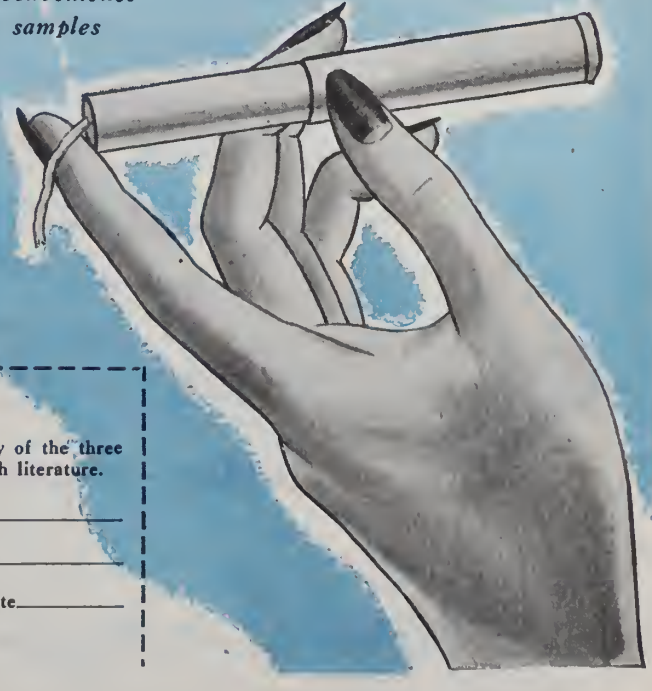
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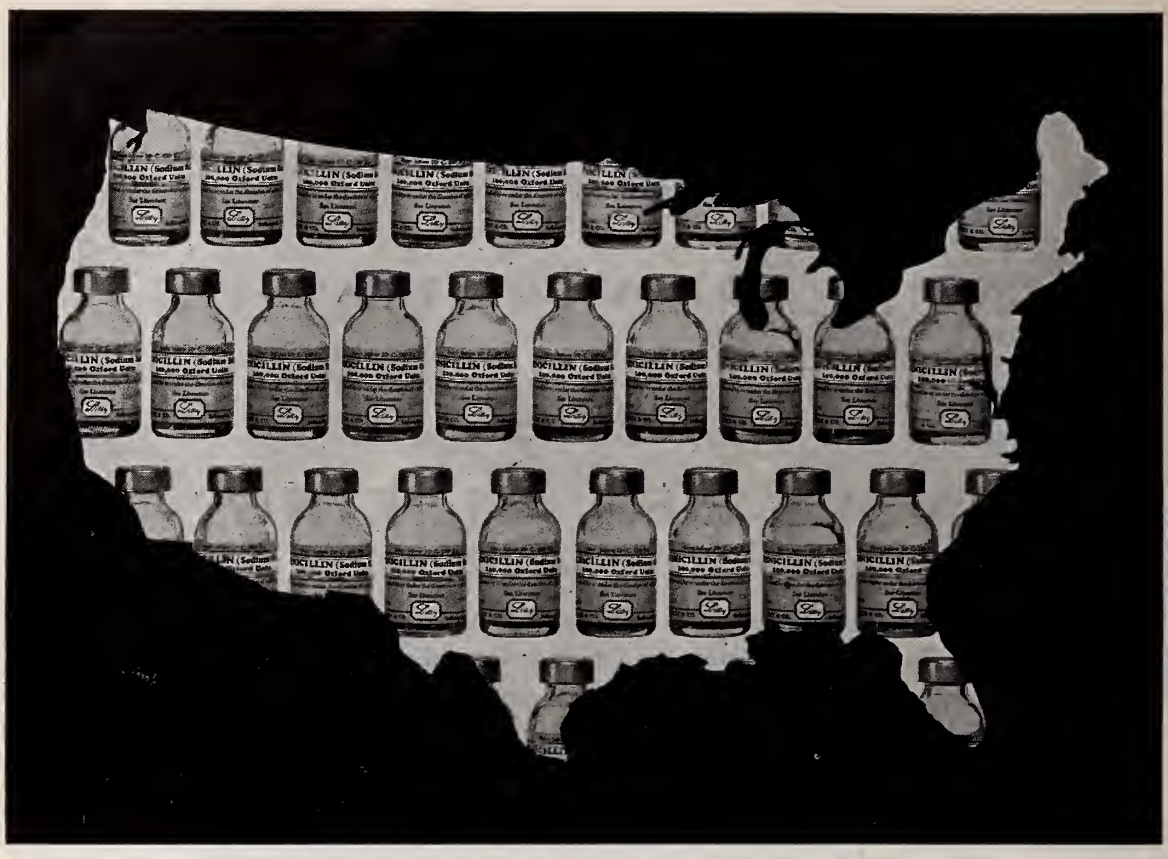
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**Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60; Proc. Soc. Exp. Biol. and Med., 1934, 32, 241; N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592.*

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OF
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Published Monthly Since September, 1904
Whole Number of Issues, 494

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# EDITORIALS

## RELEASE OF MEDICAL OFFICERS FROM ARMED SERVICES

Many complaints are being received from medical officers and their wives relative to delay in the return of officers to their communities. Among the complaints are: There are too many of us in military service, we are held in service though we have no duty assignment and have nothing to do, ships remain idle which might be used to transport us to the United States, our medical units are overstaffed but as individuals we are not eligible for release, the army and navy have educated a large number of doctors at public expense who are not being placed on active duty, the "blue eyed" boys have been retained in the United States without foreign service and should be used to relieve those of us who are on foreign duty, the civilian profession has let us down and is not using its influence to expedite our release, and so forth.

Many of their complaints are justified. On the other hand, some of them typify nursed grouches on the part of anxious individuals and groups who expect undue consideration as individuals. It is a reaction to be expected now that the active war has been terminated and the delay in return to civilian life is affecting adversely the immediate future welfare of many individual physicians.

We see no justification for retention of the present number of physicians in the army or for the present delay in the return of medical officers under established policies governing discharge. It is not being handled effectively by the War Department, which apparently did not anticipate the present situation and was not prepared to handle it promptly. We appreciate the fact that the army must guard its interests to cover future contingencies, but it is inconceivable that these contingencies will require the number of physicians which the army anticipates holding in service under its present point system.

We also have a complaint, based upon the results obtained through the Directing Board of Procurement and Assignment Service. It was our understanding that the critical needs of our communities would be given due consideration by the armed forces by the early return of

officers upon recommendation of the Appeal Committee of the Directing Board. Many of our appeals were not approved by the Directing Board, but of those which were approved we know of no instance in which the officer whose release was requested has actually been returned to New Jersey to fill a critical community need.

According to the records of New Jersey Procurement and Assignment Service, 2,908 physicians entered the armed services (including USPHS) from New Jersey. Of these, 267 entered from an intern or resident status. Of this toal 173 have been returned to their communities. There has as yet been no appreciable increase in the rate of return since V-J Day. In no week since V-J Day have more than eight officers been reported to us as having returned, and the majority of these have been discharged for physical disabilities.

The policies of the army and navy governing release of medical officers announced after V-J Day are as follows. Any attempt on our part to expedite the return of officers must be limited by these policies and the needs of communities where the physician-population ratio is less than 1-3,000.

### Army:

The following medical officers will be considered surplus and separated from the service:

1. Those having accumulated a total of 80 points.
2. Those who are 48 years of age or over (except for less than 200 scarce medical specialists).
3. Those on active duty prior to Pearl Harbor.
4. "Scarce specialists" who entered active duty prior to January 1, 1941.

Under this policy the army anticipates the release of 13,000 medical officers by January 1, 1946, and 30,000 by June 1, 1946.

Army point credits are: one point for each month of active duty, an additional point for each month of foreign duty, 12 points for each child (up to two) less than 18 years of age on V-J Day, 5 points for each campaign in which the officer took part and 5 points for each decoration.

On September 24th the lay press announced that Medical Corps officers with 45 points or 40 years of age would not be sent overseas. No official confirmation of this policy has been received in the Procurement and Assignment Office up to this time, September 26th.

### Navy:

Medical officers will be eligible for discharge who have accumulated 60 points under the following point system:

1. One-half point for each month of active duty since September 1, 1939.
2. An additional ¼ point for each month of foreign duty.
3. One-half point for each year of age.
4. Ten points (total) for one or more dependents.

It is mandatory that no officer eligible for discharge under this policy will be held on active duty for more than 120 days.

Special dispensation for release from active duty will be given those officers who are permanently limited by medical survey to shore duty as a result of service-connected disabilities.

Special consideration will be given officers holding the Medal of Honor, Navy Cross, Army Distinguished Service Cross and Silver Star, or to those awarded the Legion of Merit or Distinguished Flying Cross for action during combat.

It is estimated that 1,100 of the 13,500 medical officers now on duty with the navy are eligible for discharge under this policy at this time and that this number will be increased to 1,678 by January 1, 1946.

## MATERNAL AND CHILD WELFARE

The latest move toward the promotion of a socialistic form of government by entre through the medical profession is contained in Senate Bill No. 1318, "Maternal and Child Welfare Act" of 1945 introduced by Senator Pepper of Florida.

The Bill in substance would continue and expand the EMIC program under jurisdiction of the Children's Bureau of the Federal Department of Labor.

Under the Bill, if enacted, maternal and pediatric services would be available, without cost to the patient, to any person requesting these services regardless of income, race, creed or color.

The Bill would authorize an appropriation of $100,000,000 for the fiscal year ending June 30, 1946, of which $50,000,000 would be designated for maternal and child health services, $25,000,000 for services to crippled children, $20,000,000 for child welfare services and $5,000,000 for administrative expense incurred by the Children's Bureau.

That the amount appropriated is inadequate to provide an effective program is indicated in the remarks of Senator Pepper upon introducing the Bill. He said, in part:

"Medical care and health supervision of children is costly in dollars. Reliable authorities estimate it comes to somewhere in the range of $25 to $40 a year for each child in the United States. With 40,000,000 children under 18 that represents a total of at least $1,000,000,000 for the country. A Federal appropriation of $75,000,000 for maternal and child health and for crippled children for a year cannot go very far in meeting these all-over health needs of children. Even if it were divided with mathematical precision among all children, it would come to less than $2 a child. Of course, it will not be so divided, but that kind of calculation helps to indicate the modesty of the approach in this bill.

"Obviously, a nation-wide child-health and child-welfare program is not something that can be created in a year. For that we must have time to develop services, train personnel, develop facilities, conduct research and demonstrations, and educate parents in the use of facilities and in the application of expanding scientific knowledge. The authorizations for appropriations that we are suggesting for this year will give us a fair start toward our objective, though it will be only a beginning."

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## PUBLIC RELATIONS TOWARD COMPULSORY SICKNESS INSURANCE

Public relations should emphasize the basic defects of compulsory sickness insurance which are inconsistent or incompatible with the tenets of liberal democracy. Arguments on this basis are effective and do not arouse opposition to the opinions of the medical profession.

### Centralization of Authority

Our country was founded as a liberal democracy. Its founders very obviously recognized the danger of centralized authority and power in government. They therefore established, not a national government, but a federal government,

to coördinate the activities of a federation of states, granting each State the privilege of dealing with its own internal problems, and providing that the affairs of the States to be delegated to the federal government, would be delegated through a congress whose members were elected for limited periods of service, and administered under the direction of a chief executive also elected for a limited period of service. To circumvent these precautions we recognize the trend of factions among our people and in government to grant an ever increasing centralized authority through our Congress to both elected and non-elected officers of the federal government. This follows the European pattern which led to complete dominance of government over the people and their final enslavement to the whims and dictates of a one-man dictatorship. In those countries, Germany, Italy and Austria, the first group to be subjugated was the medical profession, and from there on, it spread to all elements of the populations. It may happen here if the medical profession fails to prevent its inroad through their own profession.

## Independence of the Individual

One of the tenets of our form of government is to allow its people as individuals to conduct their private lives, determine their own destinies and provide for their own welfare on a basis of personal initiative and freedom from interference by a dominating government. The degree to which this is accomplished determines our success and our strength as a democratic nation.

Compulsory sickness insurance exemplifies the opposite of this tenet. It encourages public dependence of the individual instead of encouraging personal initiative to maintain his own welfare. It increases the centralized control of government over the private life of the individual. This weakens the strength of a democratic state.

## The Efficiency of Compulsory Sickness Insurance

The relative efficiency of the practice of medicine as a free enterprise and its practice under a compulsory system should be revealed through a comparative analysis of disease incidence and mortality of those diseases humanly controllable under each system.

Frederick L. Hoffman, LL.D., formerly vice-president and statistician of Prudential Life Insurance Company, made such a study, comparing the vital statistics of England and Wales with the vital statistics of this country. This report was based upon the experience during the year 1934 and published in "The Weekly Underwriter".

Of the twenty-six important causes of death the mortality in England-Wales was higher in all but eight. The important exceptions were nephritis, which he believes is due to the higher incidence of this disease in our colored population, diseases of the coronary arteries, angina pectoris, cerebral hemorrhage and apoplexy.

Among the diseases whose control requires particularly prompt and efficient medical care the following statistics are quoted from his report: Mortality from erysipelas, 3.6 per 100,000 in England-Wales as compared to 1.5 in this country; cancer death rate in England-Wales 156.3 as compared to our rate of 106.3. Respiratory tuberculosis incidence rate 63.5 as compared to ours of 51.2. Inflammatory diseases of the ear and mastoid had a rate in England of 4.1 as compared to our rate of 3.2. Gastroduodenal ulcers had a mortality rate of 10.7 as compared to ours of 6.1.

The impartial report from which we have quoted demonstrates a higher efficiency of medical care and preventive medicine under our system of the practice of medicine as a free enterprise.

# ORIGINAL ARTICLES

## FRACTURES OF THE HEAD OF THE RADIUS

By Baxter L. Clement, M.D., F.A.C.S., Captain, Army Air Forces

Fractures of the head of the radius may be classified for the purpose of treatment into two groups:

Group One: Linear fractures involving the articular surface; slightly comminuted fractures even with some depression of fragments.

Group Two: Extensively comminuted fractures with gross displacement of fragments.

This report is based on the treatment and end results obtained on ten cases with group one fractures at an Army Air Base station hospital.

The majority of authors [1-12] recommend immobilizing this type of fracture with the elbow in a semi-flexed position for periods varying from one to four weeks and generally agree on conservative treatment. They disagree, however, as to the time to begin active motion. After immobilization, when the cast or splint is removed, most patients have painful elbows with loss of flexion and extension and impairment of supination and pronation of the forearm. Some of the cases present a marked disability.

The fracture may be the result of direct or indirect violence, more often indirect. Usually it is the result of a fall, with the elbow fully extended and the forearm pronated, the force being transmitted through the radius and driving the head of the radius against the capitellum and external condyle of the humerus. The clinical picture is fairly characteristic. The elbow is held in semi-flexion and pronation. Any attempt to change this position is painful. There is swelling over the external portion of the elbow and head of the radius with varying degrees of ecchymosis. Palpation of the head of the radius elicits marked tenderness. Usually no crepitation can be felt. Roentgeno-



Figure 1

Linear fracture of middle one-third of the head with depression of the fragment.

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grams should be taken and several views may be necessary to show the fracture in detail.

The following procedure was carried out on ten patients with fractures classified in Group One:

All were seen in the first twelve hours following injury. A sedative was given and the elbow prepared as for a major operative procedure with careful adherence to a sterile technique. The following bony landmarks were identified: tip of the olecranon, external epicondyle of the humerus and the head of the radius. Directly in the middle of the triangle formed by these landmarks a few cubic centimeters of two per cent Novocaine with adrenalin was injected subcutaneously. An 18-gauge needle was then introduced into the elbow joint through the center of the triangle. Continuous aspiration is maintained during the introduction of the needle. When blood is encountered, the joint has been entered and further penetration of the needle is not necessary. From 8 c.c. to 15 c.c. of fresh blood can be aspirated. Immediate relief from pain and a marked increase in the range of motion was noted in every case.

Since these patients were military personnel, it was necessary to hospitalize them. However, in civilian practice they could be treated adequately on an ambulatory status. Following aspiration the extremity was placed on a pillow in any position which was most comfortable to the patient, usually in about 90 degrees of flexion and midway between supination and pronation. Ice bags were applied to the elbow for twelve hours. Active motion was started twelve hours after aspiration and whirlpool baths were given daily for thirty minutes. During this treatment the patient was instructed and encouraged to flex, extend, supinate and pronate the elbow and forearm. After the fourth day gentle massage was started.

Treatment of fractures in the second group will not be discussed except to say when the



FIGURE II

Complete fracture through the middle one-third of the head with comminution of the lateral fragment.



FIGURE III

Linear fracture involving one-half of the head with defect in the lateral fragment and a depression of this fragment.

head is severely comminuted with marked displacement of the fragments, complete excision of the head should be done. It is advisable to remove all of the head and approximately one-half of the neck proximal to the insertion of the biceps tendon. Resection should include the periosteum. All spicules of bone and torn fragments of the periosteum should be carefully excised. One should be careful not to injure the posterior interosseous nerve.

The end results in all ten cases were excellent. Six of the cases returned to full military duty in fourteen days. The remaining four returned to full military duty before twenty days. All of the cases have been followed for a period of at least four months. The longest follow-up period was ten months. None of the patients complained of pain. There was no loss of function, instability of the elbow, anatomical deformity or disturbance of the carrying angle.

Figures One, Two and Three are roentgenograms of three cases included in this series. They represent the type of fracture under discussion and are classified in Group One.

SUMMARY

Treatment of ten cases of Group One fractures of the head of the radius by immediate aspiration of the elbow joint without immobilization and with early active and passive motion resulted in normally functioning joints in all cases. The patients returned to full military duty in fourteen to twenty days. Follow-up examinations from four to ten months later revealed no limitation of function nor complaint of pain. None of the cases have shown evidence of myositis ossificans or calcification about the head of the radius. Operative removal of the head of the radius and immobilization have no place in the treatment of fractures classified in Group One.

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## IN MEMORIAM

### COMMISSIONER WILLIAM JOHN ELLIS

**A Friend of the Doctor**

The New Jersey Neuro-Psychiatric Association is desirous of recording the regret and sorrow of its members at the untimely death on March 11, 1945, of William John Ellis, Commissioner of the Department of Institutions and Agencies, and an honorary member of this Association.

Commissioner Ellis devoted himself unsparingly, with great intelligence and understanding, over a period of more than twenty-five years, to the organization and administration of public services in this State for persons in need of assistance, treatment and care. He was alert to the contributions of psychiatry towards the adjustment of patients to community life. He sought full employment of the resources of medicine, psychiatry, and social service to secure for individuals and communities the maximum benefits of organized prevention, early diagnosis and skilled treatment, which he believed to be the sound objectives of public policy in social welfare.

His wisdom and foresight were repeatedly demonstrated by his espousal of research projects and his early advocacy and support of such new therapeutic procedures as the shock therapies.

He found time for numerous activities corollary to his principal responsibilities and interests, and by his participation in these, extended the horizons of the Department and interpreted its activities to public and private groups who thus were enabled to contribute of their strength and vision to the common purpose.

With all his prestige, and in spite of the ceaseless demands upon his time and strength, he remained simple, without affectation, friendly and accessible. We shall sorely miss his leadership and friendly spirit.

We condole with his wife, son and two daughters, and a copy of this resolution will be forwarded to them.

Dr. J. B. Spradley, Trenton
Dr. J. Berkeley Gordon, Marlboro
Dr. Theodore R. Robie, East Orange.

# NEWARK BETH ISRAEL HOSPITAL CANCER SYMPOSIUM *

**APRIL 4, 1945**

## Carcinoma of the Body of the Uterus

*Dr. Louis J. Levinson and Dr. William Brams*

In the treatment of carcinoma of the body of the uterus, there are several methods available, depending on the extent of the disease, age and condition of the patient.

1. The most frequently used is a panhysterectomy, as a rule reserved for patients who are considered good surgical risks.

2. Within recent years, there has been a tendency in some clinics to use preliminary intracavity radium followed by a panhysterectomy in six or eight weeks.

3. For those patients who are considered poor surgical risks intracavity radium therapy alone can be utilized.

4. Radium in combination with roentgen therapy is also used in selected cases, especially those adenocarcinomas of the body which originate in the lower uterine segment and invade the endo-cervix. They present a problem in therapy similar to that of primary carcinoma of the cervix.

In our clinic an attempt is made to individualize the treatment in each case. We are presenting three representative cases of carcinoma of the body of the uterus that were treated by some of the above mentioned techniques.

The first patient, A. L., aged sixty-three, was admitted to Dr. Steiner's service on January 9, 1942. Her chief complaint was severe pain in the lower abdomen, back, and irregular vaginal bleeding of three months' duration. She was extremely obese and weighed about 275 pounds. There was a rough systolic blow at the apex and her blood pressure was 160/110. On January 14, a D & C was performed. The uterus was moderately enlarged with a somewhat dilated cavity. The cervix was atrophic and dilated. Dr. Antapol reported adenocarcinoma of the uterus following his examination of the curettings.

Because of her extreme obesity, age, and apparently damaged heart, it was decided that radium therapy alone would be the safest method of treatment. On January 19, six radium capsules were packed in the fundus and one large sound was inserted in the lumen of the cervix and lower part of the body of the uterus. The total dose was 4200 mghrs. This patient has been well now for over three years. She weighs 270 pounds and has had no bleeding or discharge following her radium treatment three years ago.

The second case, S. R., aged sixty-two, was admitted by Dr. H. Suesserman for vaginal bleeding of three months' duration. She also had some mild cardiac decompensation and bronchial asthma. Dr. Lester Goldman had previously reported on a diagnostic office curetting, that the patient had an anaplastic adenocarcinoma of the body of the uterus.

Because of her poor physical condition, it was decided to use preliminary radium treatment and surgery at a future date. On June 27, 1944, under spinal anesthesia, the uterine cavity was probed and found to be markedly enlarged, dilated, and filled with neoplastic tissue. Three rubber sounds containing radium capsules were inserted into the body of the uterus, and cervical canal. A total of 5000 mghrs. was administered. Following this treatment, the bleeding ceased and her general condition improved. Dr. Comando readmitted her on November 11, 1944, and performed a vaginal hysterectomy. The gross examination showed a totally extirpated uterus measuring 10 cm. from external os to fundus and 4 cm. across at the fundus. The specimen was previously dissected. On opening, the endometrium is greyish-brown, smooth and spotted with hemorrhagic areas and measures 2 to 3 cm. in thickness. The myometrium measures 1½ cm. in diameter and is of the usual appearance.

The microscopic examination revealed fibrosis uteri. Endocervix and endometrium show-

* Presented by the Tumor Clinic Staff of the Newark Beth Israel Hospital as part of the program for Cancer Month.

ing chronic inflammatory granulation formation with numerous round-cells, plasma cells, macrophages and fibroblasts.

The patient made an uneventful recovery and was discharged on December 5, 1944.

The third patient, S. S., is a thirty-two-year-old married nullipara whose periods had always been irregular accompanied by dysmenorrhea. For six weeks prior to admission, she had been having continuous vaginal staining. She was admitted by Dr. Brams on January 25, 1945, with a diagnosis of left ovarian cyst and endometrial hyperplasia. At operation, the uterus was slightly enlarged and very fibrotic. The ovaries were atrophic and the left was somewhat cystic. A D & C and a partial resection of the left ovary were performed. The post-operative diagnosis was left cystic ovary. Dr. Goldman's report of adenocarcinoma following an examination of the curettings was totally unexpected. Dr. Brams suggested intracavity radium treatment followed by a panhysterectomy in six weeks.

On February 3, 1945, two radium sounds were inserted into the uterine and cervical canal for a total of 4000 mghrs. The internal cervical os was somewhat obstructed by an irregular mass extending from the lower uterine segment and the sounds were inserted and removed with considerable difficulty.

It was my impression at that time that the neoplasm had originated in the lower uterine segment. Five weeks later a panhysterectomy was performed. Dr. Goldman examined the uterus and will report on the findings.

### DISCUSSION

#### Dr. Goldman

The three patients presented by Dr. Levinson illustrated three different histologic types of carcinoma of the body of the uterus. The first case was a relatively benign type, classified as adenoma malignum, readily cured either by surgery or radiation. The second case was a highly malignant anaplastic type, the most radio-sensitive. The third patient had a definite adenocarcinoma.

In spite of the difference in histologic appearance, the response to radium therapy was apparently the same. Careful examination of each uterus revealed no evidence of residual carcinoma.

#### Dr. Brams

Dr. Levinson properly states that in his clinic an attempt is made to fit the treatment to the patient, and not the patient to the treatment. However, in reports from several large clinics throughout the country, this is not the usual procedure. They advise treatment with radium followed by surgery in cases of carcinoma of the body of the uterus. About four or five years ago New York Hospital reported that in cases five years after treatment the survival rate was—39 per cent with radium alone and 59 per cent with radium followed by surgery.

In seventy-five uteri that were removed following radium therapy, two out of five were found to have residual cancer cells. The average dose administered was 3500 to 4000 mghrs. The advantage to the patient in using preliminary intrauterine radium for carcinoma is that the radiated carcinoma of the body may be less liable to invade the blood stream or lymphatics at the time of operation.

Two years ago, Ward reported that a woman should have a 75 per cent chance of survival five years after radium and surgery.

Memorial Hospital reports about the same percentage of survival in 172 cases.

#### Dr. Huberman

I think that the group should be congratulated upon its fine presentation. I should like to stress the importance of diagnostic curettage. There is nothing so discouraging to a surgeon as when he does a major operation on a patient and the report of the curettings discloses an unexpected carcinoma of the uterus and he is then obliged to operate again. If the patient is over forty-five and there is a history of vaginal bleeding, she should have a curettage. The surgeon should then wait for the report of the curettings.

It might be of interest to discuss the cases of malignancy of the pelvis, cases that are hopeless and are beyond palliation from surgery and radiation therapy. When the doctor has such a patient, the question is what to do to give this individual some relief. Some advise treatment with the male hormone testosterone proprionate in such cases. Dr. Abel of Chicago has reported on five cases which he treated with male hormone and though he does not report a regression of the growth, he does claim that there is a definite feeling of well being. The treatment alleviates the tiredness and fatigue, and the general mental and physical condition is greatly improved.

## Multiple Operations for Carcinoma of the Colon

*Dr. Charles M. Robbins*

E. P., white female aged forty-seven, was first admitted to Newark Beth Israel Hospital on February 20, 1942, with complaints of abdominal cramps and vomiting. The diagnosis at that time was incomplete intestinal obstruction in the left colon. She was decompressed with a Miller-Abbot tube. An x-ray exam-

ination following a barium enema revealed neoplastic infiltration of the descending colon. Proctoscopic examination was negative. Hypertension of 220/120 was noted at this time. A first stage Mikulicz resection was performed. At operation several large mesenteric nodes were found. The liver was normal. Microscopic examination revealed an infiltrating adenocarcinoma.

The patient returned in March, 1942, for closure of colostomy. This was unsuccessful.

Nineteen months later, she was readmitted with a superficial abdominal mass associated with pain in the abdomen and pyrexia. A local excision was performed. Microscopic examination showed skin and subcutaneous tissue involved by metastatic adenocarcinoma, necrosis, and suppuration.

The patient again was readmitted during March, 1944, with a recurrence of symptoms. At this time a second Mikulicz operation was performed for metastatic carcinoma of the colon. Closure, later attempted, failed.

In November, 1944, the patient was readmitted for the fifth time with a fecal fistula. An attempt was again made to close the colostomy. The patient was discharged on December 13, 1944.

Since her last operation the colostomy opening has remained closed. She has gained weight and is feeling well.

## Endocrine Therapy in Advanced Carcinoma of the Prostate

*Dr. Rita Finkler*

The relationship of the endocrines to carcinoma of the prostate was vividly brought to the attention of the medical profession by Huggins and Clark in 1940.

In their experiments on the dog they have shown that the administration of androgens caused hyperplasia of prostatic epithelium and that the administration of estrogens or castration caused a regression of the hyperplasia.

This work was based on the earlier reports of Zuckerman and Parks on the effects of androgens and estrogens on the prostate and seminal vesicles of the immature monkey.

Huggins and his associates have extended their work to the human and since reported an increasing number of patients with advanced prostatic carcinoma treated with orchiectomy or estrogenic therapy or both.

The prompt and spectacular relief from the symptoms of advanced prostatic carcinoma (urinary obstruction, pain, anorexia, loss of weight and vitality, insomnia and mental depression) has stimulated numerous clinicians, especially the urologists, to apply this revolutionary method of treatment to the doomed individuals in private practice, in the clinics and in the wards of large urological centers.

According to the statistics of Bumpus, who reported the analysis of 1000 untreated cases of prostatic carcinoma, 66 per cent of cases with metastases died in the first nine months. When diagnosis of carcinoma was made without demonstrable metastases, the life expectancy was one year; when the occurrence of carcinoma was traced back to the appearance of the first symptom, the average life expectancy was thirty-one months.

Since the introduction of castration and estrogenic therapy as means of palliative control of the progress of prostatic carcinoma with demonstrable metastases, life expectancy of the patients has been considerably prolonged, and many clinicians are reporting patients treated by either estrogens or castration or both, who are still alive two and one-half years after institution of therapy.

Not only has life been prolonged and the patients relieved of their distressing symptoms, but many have returned to their former occupations and general usefulness.

The choice of the type of therapy depends on the presence and the degree of metastases. This can be estimated by clinical evidence, roentgenographic findings and the determination of serum acid phosphotase and alkaline phosphotase.

According to Guttman and his associates, the normal upper limits are as follows:

Acid serum phosphotase—
3.5 units per 100 cc. of blood
Alkaline serum phosphotase—
10 units per 100 cc. of blood

Both of these are elevated in the majority of

cases of metastatic prostatic carcinoma. The elevation of serum acid phosphotase, however, is vastly more important. There are a considerable number of cases of prostatic carcinoma with metastases which do not show such an elevation. When the demonstrable elevation of serum acid phosphotase is present, castration or estrogenic therapy causes a prompt reduction in this level and thus may act as a guide to the efficacy of the therapeutic approach used. To date we have numerous reports on large series of cases treated with estrogens alone, castration alone, or a combination of both. The consensus of opinion, however, is that both of these methods should not be used simultaneously, but one should follow the other at the first indication of recurrence of original or metastatic carcinoma. Such a recurrence would be evidenced either by the reappearance of the original symptoms, by roentgenographic evidence or by the rise in serum acid phosphotase.

Both castration and endocrine therapy have their advantages and disadvantages. Both result in prompt alleviation of pain and spectacular relief of other symptoms of advanced carcinoma in the majority of cases.

Both methods have an equal chance of arresting temporarily bone metastases and even causing healing of metastatic lesions. Both of these methods cause reduction in acid phosphotase values in the majority of cases.

The disadvantages in castration, however, are the necessity of hospitalization and a certain amount of shock and mental hazard.

From the endocrine point of view, castration causes compensatory overactivity of the anterior pituitary with the resulting vaso-motor disturbances, headaches and insomnia. The pituitary overactivity frequently causes secondary thyroid and adrenal cortex overactivity. It is well known that the adrenal cortex is capable of producing androgens and may thus partially nullify the effect of castration.

On the other hand, estrogenic therapy depresses the androgenic activity of the testes and the adrenal cortex. Its disadvantages are the need of continuous administration as well as its remotely possible carcinogenic effect on the breast. The therapeutic dose of 1-3 mg. daily as employed by numerous clinical investigators for the last four years has never been known to cause breast carcinoma. Even large doses, 16-80 mg. used daily, experimentally by Moore, Gordon, and Wattenberg produced marked hyperplasia of mammary duct epithelium but not carcinoma.

Whether orchiectomy or endocrine therapy is decided upon as the initial procedure, all investigators agree that the life of the patient is prolonged when one method follows the other when the need arises. They also agree that trans-urethral resection and prostatectomy when possible add additional comfort to the patient. The surgical approach, however, is a purely urological problem and will be discussed by Drs. Goldstein and Seidman.

I wish to present a brief history of a patient treated by all three methods and who is alive now, seven years after the diagnosis of carcinoma of the prostate was made.

### CASE REPORT

J. F., who is now sixty-nine years old, was admitted to the Newark City Hospital in 1938 for carcinoma of the prostate. He was operated upon by Dr. O'Crowley, or the members of his service, and two-stage prostatectomy was performed. In July, 1941, he was admitted to the Newark Beth Israel Hospital with dysuria and other symptoms of a recurrent prostatic carcinoma. He was treated on Dr. Rothhouse's G. U. Service. An x-ray of the chest at that time did not show any evidence of pulmonary carcinoma. Following surgery the patient received palliative x-ray therapy (Dr. Levinson) from July 23 to October 9, 1941. The response was poor and the therapy was discontinued because of severe reactions. He was again admitted to the hospital on May 29, 1942, on Dr. O'Crowley's service with Drs. Rothhouse and Goldstein in attendance.

At the time the x-ray examination of the lumbo-sacral spine and pelvis showed numerous osteoblastic areas of metastases.

Because of the above findings, it was decided to perform a bilateral orchiectomy and Mr. F. was operated on June 4, 1942, under spinal anesthesia.

The pathological reports were as follows:

Gross: Slight hydrocele of both testes—otherwise normal.
Microscopic: Normal; testes showing an increase in interstitial cells and no spermatogenesis.

The patient made an uneventful recovery and was discharged on June 13, 1942, and admitted to the G. U. clinic on June 16, 1942, with the following complaints: nocturia, frequency, headaches, tachycardia, and hot flashes. Because of the latter symptoms, he was referred to the Endocrine Clinic.

### CLINICAL COURSE—ENDOCRINE CLINIC

On his admission to the Endocrine Clinic in September, 1942, his weight was 198 pounds.

Three injections of Oreton, 10 mg. each, were given on January 13, 16 and 20, through a misunderstanding. This was quickly changed to stilbestrol, 1 mg. twice a day. The patient responded promptly by diminution and disappearance of hot flashes and headaches and by a general improvement in vitality.

X-ray studies on January 27, 1943, were as follows:

No. 335—Examination of the thorax shows no cardiac or pulmonary pathological process. A slight alteration is observed in the cancellus structure of the first rib on the right side. At the moment the findings are without definite etiological characteristics. Reëxamination at a later date is advised. Several areas of density are noted in the thoracic vertebrae. These are probably neoplastic metastases.
Conclusion: Lung fields negative at the moment; probable metastases—thoracic spine.

At this time he was referred back to the Radiation Therapy Department. No therapy was administered, but another x-ray was taken on February 19, 1943, revealing multiple areas of metastatic invasion.

On his own accord the patient discontinued the medication for two months and he returned to the clinic on June, 1943, with a recurrence of hot flashes and all symptoms. The therapy was resumed and the patient was told to report regularly to the clinic.

An x-ray in October, 1943, showed no further regression of the metastatic lesions.

In October, 1944, the patient once more discontinued therapy for five or six weeks and again all his symptoms recurred. He was again placed on medication. When he stopped taking the stilbestrol for a period of three weeks in January, 1945, his symptoms recurred. He also had a recurrence in his urinary symptoms and was treated by Dr. Seidman privately, who later sent him to the Newark Beth Israel Hospital Urological Service. X-ray studies of the pulmonary area were negative for carcinoma. Serum acid phosphotase taken on the fifth day after cessation of stilbestrol therapy was normal. Previously a serum acid phosphotase carried out through the Endocrine Clinic under similar circumstances was also normal.

Stilbestrol therapy was then resumed, the patient discharged from the hospital and he now attends the Endocrine Clinic regularly.

## DISCUSSION

### Dr. Herman Goldstein

We all recognize the fact that carcinoma of the prostate is a devastating and hopeless disease. Since Dr. Finkler has limited her paper to a discussion of the hormone therapy in a case of carcinoma of the prostate, I shall also speak only of the treatment we can offer in this disease and the results we may expect from that treatment.

Treatment may be considered under the following headings: X-ray, Castration, Hormones, and Surgery. X-ray treatment to the testes, although still used by some men, has been more or less discarded as an active means of therapy. Castration is now carried out in many clinics with, as a rule, excellent primary results, pain, urinary symptoms, and discomfort disappear like magic and in many cases metastatic areas fade out completely. These advantages, however, are temporary and one must not be misled into thinking that a cure is being effected. Invariably, the prostatic carcinoma continues to grow, urinary symptoms make their appearance again, metastases recur, and the patient dies with carcinoma of the prostate. It is interesting to note that in the early days of castration, a bilateral epididymoörchidectomy was performed. This left the scrotum empty and was a potential source of great emotional upset in many patients. Today we remove only the seminiferous tubules, leaving the rest of the scrotal contents intact. The use of stilbestrol is advocated by many workers in this field and the results following its administration closely resemble those seen after castration. Opinion is divided, however, on whether to use castration or stilbesterol first. As a matter of fact, some men use both methods of therapy at the same time. In the field of surgery, we can offer the patient radical prostatectomy. This is an heroic procedure with a high mortality and it is the opinion of many urologists that they would rather carry their patients along as far as they can with castra-

tion and stilbesterol, rather than subject them to this type of surgery. Of course transurethral resection or cystotomy may be performed with relative impunity as indicated in the individual case, but here again our efforts are extended towards making the patient as comfortable as possible.

In the final analysis, the use of the therapeutic measures at our command, either singly or in combination, differs with the personal opinion of the urologist as seen in the light of his experience with that particular type of therapy.

DR. SEIDMAN

This is not a cure, most of the cases do not get prolonged response from castration and stilbesterol. There is no general agreement on the action of castration and stilbesterol as to which should be administered first or both together. Older men, without marked symptoms, do well on stilbesterol.

DR. DANZIS

Meades reports that in twenty-one out of sixty-five cases, patients had recurrences in six months following castration. Stilbesterol is of significance only in low grade tumors. But even these patients responded favorably for only one or two years.

DR. M. REICH

In 145 cases in Veterans' Hospital since 1940, we found that castration and stilbesterol gave prompt response. Sixty-seven patients died, others are doing well.

## WITH NEW JERSEY MEDICAL AUTHORS

Compiled by MILDRED V. NAYLOR, Librarian, Academy of Medicine

It is requested that any New Jersey physician who publishes an article outside the state, notify the Editorial Office in Trenton, giving the title of the paper and the name of the periodical, as well as the month, date, volume and page number. It would also be helpful to this office if members would notify us of articles published by their colleagues.

BONNET, WILLIAM L.—Mercerville (in service)
Chest x-ray in war time industrial examinations. J. Med. S. New Jersey 42: 253-261, Aug. 1945

CARPENTER, C. C.—Summit (in service)
Management of the recurrent vesiculopustular eruptions of the hands and feet. J. Med. S. New Jersey 42: 262-267, Aug. 1945

COHEN, SAMUEL—Jersey City (in service)
Treatment of pneumonia. J. A. M. A. 128: 1219-1224, Aug. 25, 1945

FISCHELIS, ROBERT P., D. Phar.—Trenton
To the graduates of 1945. New Jersey J. Pharm. 18: 16-20, Aug. 1945

FRANKEL, EMIL—Trenton
Neuropsychiatric screening of selective service registrants. J. Med. S. New Jersey 42: 268-273, Aug. 1945

HARRIS, T. N.—Atlantic City
Erythrocyte sedimentation rate in rheumatic fever, its significance in adolescent and overweight children. Am. J. Med. Sci. 210: 173-181, Aug. 1945

JENNINGS, ROBERT E.—East Orange (in service)
Adhesions of the labia minora in children. Review of the literature. Urol. & Cutan. Rev. 49: 529-531, Sep. 1945

LODER, HORACE B.—Bridgeton (in service)
Duodenal ulcer in a large army camp: incidence and statistical analysis. Mil. Surgeon 96: 492-497, June 1945

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MERSHEIMER, WALTER L.—Jersey City (in service)
Mobile surgical units for amphibious warfare. U. S. Nav. M. Bull. 45: 551-556, Sept. 1945

OTT, WALTER—see Seeler, Albert O.

PEER, LYNDON A.—Newark
Contributions to plastic surgery during 1944. Arch. Otolaryng. 42: 56-79, July 1945

RANSOHOFF, NICHOLAS—Long Branch
Curare in the acute stage of poliomyelitis. J. A. M. A. 129: 129-30, Sep. 8, 1945

REILLY, H. CHRISTINE; ALBERT SCHATZ and SELMAN A. WAKSMAN—New Brunswick (New Jersey Agricultural Station)
Antifungal properties of antibiotic substances. J. Bact. 49: 585-594, June 1945

REITMAN, NORMAN—New Brunswick (in service)
Abdominal manifestations of rheumatic fever: Description of right rectus syndrome. Ann. Int. Med. 22: 671-679, May 1945

SCHATZ, ALBERT—see Reilly, H. Christine

SCHEFRIN, ALEXANDER, and ABRAHAM SHECHTMAN—Passaic
Congenital thrombopenia. Am. J. Dis. Child. 70: 29-30, July 1945

SEELER, ALBERT O., and WALTER H. OTT—Rahway (Merck & Co.)
Studies on nutrition and avian malaria. III. Deficiency of "folic acid" and other unidentified factors. J. Infect. Dis. 77: 82-84, July-Aug. 1945

SHECHTMAN, ABRAHAM—see Schefrin, Alexander E.

SHLIONSKY, HERMAN — Cedar Grove (In service) (with others)
Functional enuresis in the army; report of a clinical study of 100 cases. War Med. 7: 297-303, May 1945

WAKSMAN, SELMAN—see Reilly, H. Christine

## LOCAL REACTION TO PENICILLIN GIVEN BY MOUTH

E. CLARENCE KERN, M.D., F.A.C.S., Montclair, N. J.

Mrs. B., age 38, complained of chronic discharge from the nose. She gave a history of having had both antra irrigated a number of times, following which an antrotomy was done. X-ray showed + involvement of the left antrum. Allergy tests indicated that she was sensitive to several foods, the more marked being green beans and onions. There was a slight deflection of the septum and both middle turbinates were in contact with it. There was a small amount of mucopus in the nasopharanx and small pieces of tonsillar tissue remaining at the base of each fossa.

Inasmuch as I have had some good results, in several similar cases, from the oral administration of penicillin, a trial of this treatment was instituted. Five cc. of saline was injected into the original flask containing 100,000 units of penicillin. The solution was then drawn out and placed in a dropper bottle. The patient was instructed to keep this under refrigeration and to make up a fresh bottle each day. The dosage prescribed was ten drops placed on the tongue every two hours and held in the mouth as long as possible before swallowing.

Six days later the patient returned, having used five bottles of penicillin (i. e., 25 cc. of the saline solution, 500,000 units of penicillin). She reported that on the second day of treatment the drops began to sting and burn a little. By the third and fourth day, the tongue and throat were very sore, the gums tender. The tongue, she said, felt as though it had been scrubbed with a stiff brush. Each administration of the penicillin seemed to make the condition worse. After the fourth day she stopped the treatment.

Examination revealed a marked injection, without edema, of the soft and hard palate and oro-pharynx. This presented a rather blotchy appearance, with many petechial hemorrhages. The gums were somewhat red. The tongue was fissured and, according to the patient, appeared cleaner and redder than usual. All treatment was suspended and the patient was asked to return in three days. When she returned all redness and irritation had disappeared.

## THE BOARD OF CHILDREN'S GUARDIANS HEALTH PROGRAM*

By HON. JOSEPH E. ALLOWAY, Trenton, New Jersey
Executive Director, Board of Children's Guardians

### TYPES OF CARE

The Board of Children's Guardians is New Jersey's public child caring agency and at present is supervising the welfare of children and families in the following groups:

#### *Dependent Children's Department*

This group includes 10,129 children who are dependent because they have no home or because the home they had was found to be unfit. These children are committed by county courts of competent jurisdiction and the state then becomes their legal guardian until they reach age 21 unless they are discharged earlier.

The Board believes that every child should be provided with as normal an environment as possible. Therefore, most of these children are placed in carefully selected foster homes, particular attention being given in regard to:

1. the religious background of the child;
2. the financial security of the foster home so that the board paid will be used solely for the benefit of the child;
3. living arrangements and neighborhood environment conducive to wholesome living; and
4. the willingness of the foster parents to accept the child as a welcome member of the family group.

In some instances foster home placement is not feasible because of the child's physical or mental condition. These children are placed in institutions particularly suited to their type or needs.

* Reprinted from The Medical Way, May, 1945.

*Home Life Department*

This group includes 8,827 children and their mothers, comprising 3,594 family groups. Provided the necessary legal requirements are met, the Board of Guardians furnishes cash assistance when there is financial need in the home due to the removal of the father's support through death, illness, imprisonment, deportation, or absence from the household. Assistance is given until the children become sixteen, or eighteen if they are continuing to go to school, unless, of course, the family's circumstances change and this financial help is no longer required. Since July, 1943, the Board has been responsible for the mother's support as well, thus making it financially possible for her to remain at home to give her children the care they need.

*Child Welfare Division*

The Board of Guardians also provides case work services of a non-financial nature to children (from birth to age 21) who are not eligible for assistance through the other two departments but who are in need of specialized care. This division, which operates in seven of the more rural counties, is sponsored and financed by the U. S. Children's Bureau under provisions of the Social Security Act.

The children come to this division's attention through referral by individuals and agencies on account of neglect, delinquency, maladjustment, physical and mental handicaps and illegitimacy when there is no other agency in the county with facilities for handling the particular problem. The division is able to provide intensive service to the child or family referred and in this way is able to solve problems and adjust many situations that might otherwise develop beyond possibility of correction. During the 1944 calendar year services were initiated for 866 children and terminated for 743, with 1,164 remaining under supervision at the end of December, 1944.

## Health Services

Since the Board is legally and financially responsible for the health care of the children and mothers in the Home Life Department and for the children in the Dependent Children's Department, advantage is taken of every available facility that will promote their normal development into healthy, happy, useful members of the communities in which they live.

The Board's program for health care includes:

1. Healthful living conditions in the home and in the community.
2. Early immunization and vaccination against communicable diseases which are recognized as causes of serious conditions in later life.
3. Maintenance of adequate medical and dental facilities.
4. Periodic physical and dental examinations and correction of any defects disclosed.
5. Treatment of long-term illnesses, such as tuberculosis, diabetes, venereal disease, etc.
6. Adequate care, in case of illness, in the home or in the hospital.

Bills for such health care are paid direct by the Board of Guardians to the person or institution rendering the service, the total cost being divided equally between the counties and the state. Although the Social Security Board participates financially in the Home Life Department assistance payments, due to the federal maximums allowed for each case and due to the Social Security Board's policy of not sharing in payments made direct by the agency, it does not participate in the health costs.

## Advisory and Cooperative Groups

As such an extensive health program is possible only because of the close coöperation of physicians, dentists, psychologists, hospitals and others who are interested, the Board is extremely fortunate in having a professional advisory group, composed of physicians, a dentist, a hospital representative, a nurse, and its executive director, to serve as a health committee. Included in this professional group are specialists in the fields of medicine, pediatrics, dentistry, school health and hospitalization, all of whom contribute of their time and services to advise in health matters.

In addition, there is a group of physicians and dentists, including those who are specialists in certain fields, who serve on the Board's coöperating staff in caring for the medical, surgical and dental needs of the children and mothers. Each foster mother and mother is supplied with a list of the coöperating physicians and dentists who are conveniently accessible in her area and she is given free choice of those whose services she wishes to use.

The hospitals, too, are a most essential component of the Board's health program and have been extremely helpful in supplying the hospitalization needed by the mothers and children.

The entire professional coöperating group merits the high appreciation and esteem of the Board, which takes this opportunity to extend a grateful "thank you". For without this service the greatest part of the Board's objectives in planning for the future of these children would be lost.

# RADICAL RESECTION OF CARCINOMA OF RECTUM AND/OR RECTOSIGMOID IN CONTINUITY WITH RETENTION OF THE ANAL SPHINCTER

ABRAHAM O. WILENSKY, M.D., New York

The two cases, the histories of which are given herewith, illustrate the conservative possibilities in the radical operation for carcinoma of the rectum and/or the rectosigmoid, of not sacrificing but of retaining the anal sphincter. In the modern and up to the present time usually practiced form of operation, it is generally accepted as essential that the entire lower bowel be removed including the anus—a procedure which in very many of the cases I believe not at all necessary.

Case 1.—M. H., Fifth Avenue Hospital, No. 6304.

This is a man in the fifth decade of life with symptoms extending over a period of six months of increasing constipation, pain, and some bleeding. The lower border of the easily palpable tumor was 3 inches from the anal margin and the upper border was indistinctly palpable about 2 inches above this. There being no medical or other contraindication to the performance of the operation, the patient was prepared for the latter in the usual way.

The removal was done through the sacral and perineal approach with the following technic:

The anus was closed by a temporary suture. An incision was made beginning about one inch and a half above the anal margin and extending upwards along the left side of the coccyx and sacrum. The coccyx was excised. The rectum, including its capsule, was freed posteriorly in the hollow of the sacrum as far as the finger would reach. Then the dissection was continued laterally on either side and anteriorly until the entire periphery of the bowel was free, and thereafter, upwards on all sides until the peritoneal reflection at the bottom of the pelvis was reached. In this case, fortunately, it was possible to push the peritoneum away without opening into the peritoneal cavity. A sufficient extent of normal bowel—2 inches on the lower, and 3 inches on the upper end—on either side of tumor-bearing area was then available and was considered adequate for the resection. The bowel was delivered into the wound. The extent of the resection was mapped off with clamps and the tumor-bearing area was excised. An immediate suture of the two open ends of the bowel was done in layers as follows: one layer for the capsule; one layer for the muscularis and submucosal layer; one layer for the mucous membrane including with it a very little of the submucous layer.

One rubber tube was introduced into the hollow of the sacrum. Two small packings were introduced on either side of the suture line, and 8 grams of sulfanilamide powder were insufflated all over the operative field. Closure was made up to the point of emergence of the drainage apparatus by uniting the cut margins of the levatores ani muscles, by suturing the deep fascia over this and by closing the skin. All the sutures except the skin suture was of 20 day chromicized catgut. The occluding anal suture was removed.

The patient made a very uneventful convalescence. At the end of the first week there were very normal and adequate bowel evacuations through the anal aperture, and there was a moderate fecal leakage through the drainage opening. Thereafter this fecal leakage decreased progressively until the time of discharge from the hospital when there was no fecal leakage of any kind and only a very small amount of purulent discharge. The wound was completely healed in one month's time. The patient has been seen regularly since. At the present time, the line of union in the bowel can be distinctly felt; it is soft and shows no evidence of stricture or infiltration and it is amply large enough for all functional purpose.

The operatively removed specimen showed a malignant tumor almost encircling the bowel and not penetrating the thickness of the bowel wall. There were no enlarged lymph nodes in the mesorectum. The histology of the growth was that of a mucogenic adenocarcinoma, grade III (pathology No. 3063).

Case 2—N. G., Park East Hospital, No. 16132.

This is a man in the fifth decade of life with a history extending over six months of bleeding, pain and increasing constipation. A tumor was not palpable by rectum. He was studied by x-ray and procto-sigmoidoscopy several times unsuccessfully. Finally, a biopsy was obtained which showed the presence of a malignant tumor at the junction of rectum and sigmoid. There was no evidence of any metastatic or other malignant deposits anywhere else in the body.

The man was moderately hypertensive and there was a history of a mild coronary episode about a year previously from which the man made a very satisfactory recovery, so that he was again able to go about his daily occupation as well as previously. Otherwise the patient was in very satisfactory condition for operation. Electrocardiographic studies did not contradict this impression.

The patient was prepared in the usual way, but somewhat more attention was paid to the necessary catharsis than was usually practiced in these cases. The general cardiovascular condition received the usual attention by the attending internist.

The radical removal of the tumor was done through a combined abdomino-perineal-sacral approach in one stage as follows:

Step I—An incision was made through the abdominal wall through the lower half of the left

rectus muscle and the abdomen was thoroughly explored. No other neoplastic deposits being found, the operation was proceeded with.

The abdominal cavity was carefully packed away and the sigmoid loop was drawn out of the abdominal cavity. The usual "U"-shape incision was made at the bottom of the pelvis through the peritoneum and upwards on either side of the sigmoid and rectosigmoid mesentery. The rectosigmoid was freed posteriorly and laterally as far down as the sacrosciatic notch. Anteriorly it was freed from the base of the bladder as far as it was conveniently possible. The entire loop was then pushed down into the cavity thus created, and the pelvic peritoneum was sutured across, thus making a new pelvic floor. A rubber tube was introduced for drainage down to the suture line, and the abdominal wound was closed in layers in the usual way. This completed the first step of the operation.

Step II—The patient was turned on his right side with the knees sharply flexed on the trunk. After due preparation of the skin, the anus was closed temporarily with a suture. Then an incision was made from about one and one-half inches above the posterior margin of the anus up along the left side of the sacrum. The coccyx was removed and approximately one and one-half of the lower segments of the sacrum were cut away with chisel and mallet. The rectum within its capsule was identified and was freed posteriorly up into the hollow of the sacrum. Almost immediately the cavity was entered into which had been fashioned during the first part of the operation, and which housed the liberated rectosigmoid. It was then possible to withdraw through the sacral wound the liberated rectosigmoid. Thereafter the dissection was continued in the lower end of the loop until sufficient normal bowel for the resection and subsequent anastomosis was obtained.

The tumor-bearing area with about 2 inches of normal bowel at the lower end and about 3 inches at the upper end was resected between clamps and thereafter the two ends of the bowel were anastomosed with 3 layers of sutures as follows: one layer for the rectal capsule and perisigmoidal fat; one layer for the muscularis going partially into the submucous layer; one layer for the mucosa also including a little of the submucous layer. Four grams of sulfanilamide powder were insufflated all over the sacral wound and pelvic cavity. The outer wound was closed in layers uniting individually the levator muscles, the deep fascia and the skin. Drainage was provided by one rubber tube into the hollow of the sacrum, and 2 packings on either side of the suture line in the bowel. Finally, the temporary anal suture was removed.

The patient reacted very well from the operation. Beginning on the third day and up to the end of the first week, there was some difficulty with abdominal distention but then good bowel evacuation occurred and continued thereafter. About the tenth day, fecal discharge appeared in the sacral wound. For a few days thereafter, there were fecal movements mostly through the sacral wound and to a lesser extent through the anus. But thereafter the proportion became reversed and by the end of the third week all of the bowel evacuations occurred through the anus. Only a slight purulent discharge came through the sacral sinus. At the end of the fourth week, the patient was discharged from the hospital with the abdominal wound completely healed and with a negligible sacral wound. The bowels were functioning excellently and the patient felt very well.

The operatively removed specimen was histologically an adenocarcinoma with invasion of the pericolonic fat tissue at one site (pathology No. 11008).

## DISCUSSION

The gross morphological, and the microscopic histological characteristics of the given tumor do not provide any criteria for making a decision regarding the type of operation, or regarding the retention or sacrifice of the sphincter. Similarly, the separation of the tumor into various clinical groups of malignancy is not of much practical value when based upon such evidence. Purely inflammatory lymph glands and those in which metastatic neoplastic foci are present are frequently indistinguishable and offer no immediate help during the operation in calculating the lymphatic spread of the tumor. In any event, these criteria are of no bearing in the decision to retain or to sacrifice the sphincter.

The radical operation is technically possible when the tumor has not involved the pelvic wall or the adjacent viscera too extensively, when lymph node metastasis is not beyond reach, and when distant metastases are not present. One can widely remove the entire malignancy with all of its lymphatics and all anatomically associated lymph glands; one can include a wide dissection and excision of any suspicious tissue, if the tumor has already perforated the bowel wall; and, if necessary, one can also include the removal of any neighboring organ (uterus, prostate, etc.) if it should seem to be not too extensively involved by the growth.

Retention of the sphincter is possible whenever a radical operation is possible, and when the lower border of the malignancy is at least three inches from the anal margin.

Healing at the line of union in any such resection in continuity depends, of course, upon the available blood supply and this, in turn, depends upon the point of ligation of the superior

hemorrhoidal artery. A high ligation is frequently necessary but this should and can be tempered by the necessities of the occasion, and the will not to be unnecessarily ruthless when the occasion does not demand it. If there has been judicious arrangement of the lines of section, a relatively good blood supply can be retained and the amount of marginal necrosis can be limited. Primary union between the two ends of the bowel is not the rule and should not be expected; nor should its non-occurrence disturb one. Commonly a fecal fistula forms and the wound heals thereafter completely by granulation.

Resection of the rectum or of the rectosigmoid in continuity with retention of the sphincter undoubtedly creates a greater technical problem than total extirpation of the rectum and anal sphincter. Two difficulties prevent a wider willingness to conserve the sphincter in suitable cases. The first is the difficulty of securing primary healing in the line of intestinal suture. But this is actually no greater than in similar resections of the sigmoid proper with end-to-end suture and there should be no differentiation on this score. The second difficulty has been infection. But modern chemotherapy (a combination of antigas serum and drugs of the sulfonamide group used before operation, locally in the wound, and immediately thereafter) has made this risk relatively small. Most important of all, there is necessary a willingness and technical ability on the part of the surgeon to undertake this increased technical problem and the sufficient availability of good nursing care for the longer period of postoperative care which this type of operation entails.

At the present writing, one may not in this kind of major surgery expect the smoothness of convalescence and healing usually obtained in other types of major surgery which carry the possibilities of primary suture and healing, but the reward in personal satisfaction and in gratefulness of the patient is so great as to make the effort very much worthwhile.

The method of approach for the performance of the radical operation does not materially alter the possibility of doing a resection in continuity and retaining the sphincter. The latter may be combined with any of the types of combined abdominoperineal or abdominosacral approach and technic as well as with purely posterior types of operation via the sacral or perineal route. In the light of our present knowledge of the spread of the disease, the type of operative approach should depend on whether the growth is entirely below the peritoneum, above and below, or entirely above, as well as whether the disease is still local or has spread to the lymphatic channels.

Generally speaking, it is true that in the case of malignant adenoma, the disease can be successfully eradicated equally as well by local excision as by total proctectomy. This should stimulate surgeons to consider a modified radical excision when conditions appear favorable.

In other cases, sufficiently radical resection of the rectum in continuity with immediate end-to-end direct anastomosis, can be carried out from below. The method was used by Grey-Turner with considerable success in 1935, and by Wood and Wilkie earlier. The various steps of the operation include incision along the left border of the sacrum well down below the coccyx, with or without excision of the coccyx, and, if necessary, the lower segment of the sacrum and sufficient liberation of the rectum and its fatty capsule and mesorectum, and glands well into healthy tissue. The tumor-bearing portion of the rectum is sectioned between clamps and the proximal extremity is sutured to the anal stump in the orthodox manner.

In very favorable cases, especially in women with a justomajor type of pelvis, it is possible to avoid resection of the sacrum and sometimes even of the coccyx. This is the perineal type of operation. It carries with it many advantages from every point of view.

All growths below the peritoneum that are reasonably early and mobile should be removed by the perineal or sacral method rather than by a combined operation, and whenever feasible with immediate anastomosis. Those that are partly above and partly below can, in many instances, be dealt with in the same way, provided that they are not too far advanced.

For the latter type of case, however, and for all operable cases in which the evidence

points to advanced disease, with the exception of those growths above the reflection which can be dealt with radically by Hartmann's operation, the combined abdominoperineal or abdominosacral procedure is indicated. This permits the preliminary examination of the abdominal viscera and the determination of the extent of the upward spread which is essential for the operation.

There is no doubt that all of these difficult and complicated operations should be done in one stage. It is very remarkable how well patients, who are well prepared, stand these extensive procedures.

The only absolute contraindication to the retention of the sphincter is the presence of the malignancy within the area of the primary anal canal below the embryological line of union of the latter to the descending rectal portion of the developing alimentary canal. This is so because in these cases the line of lymphatic spread is downwards and forwards across the perineum and upwards to the inguinal glands.

SUMMARY

Emphasis is made upon the easily understood advantage of retaining the anal sphincter in the radical operation for the removal of a carcinomatous lesion of the rectum and/or recto-sigmoid; upon the feasibility of accomplishing the retention of the sphincter in all types of perineal and/or sacral approach and in the combined abdomino-perineal and/or sacral operation; and upon the fact that this is possible in all cases in which there is present at least 3 inches of normal terminal bowel distal to the lower margin of the tumor. Both the immediate and late results show that the retention of the anal sphincter does not interfere with the radicality of the selected type of operation; and patients are still well and in good health up to 20 years following the operation.

12 East 87th Street

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## REPORT EMPHASIZES IMPORTANCE OF THE RH FACTOR IN THE BLOOD

### Pregnancy May Cause Hemolytic Reactions when Transfusions of Positive Type Are Given 8 to 23 Years Later

The importance of the Rh blood factor in pregnancy is emphasized in a paper in *The Journal of the American Medical Association* for March 17 reporting that when women are given transfusions of Rh positive blood from eight to twenty-three years after their last pregnancies hemolytic (blood cell destroying) reactions may result. This evidence that pregnancy may cause permanent sensitivity to the Rh factor when a woman with an Rh negative type receives a transfusion of Rh positive blood, thus causing a reaction in which the red blood cells are destroyed, is reported by Lawrence E. Young, M.D., and Donald H. Karlher, M.D., of Rochester, N. Y.

These observations and the cases reported in the study support the recent conjecture that immunization produced by the Rh factor during pregnancy probably persists for life.

"Transfusion reactions," the two physicians warn, "due to Rh incompatibility may be typical or they may be bizarre, and therefore minor reactions can easily go undetected. However, if the Rh negative patient who has this minor reaction is given another transfusion of Rh positive blood she may have a more violent reaction which could prove fatal. It is of the utmost importance therefore to investigate all reactions, minor or severe, so that the exact cause can be determined and a recurrence of the accident, perhaps in a more severe form, be prevented."

Wilensky, A. O.: Retention of the Sphincter in the Radical Operation for Carcinoma of the Rectum and Rectosigmoid. N. Y. State J. of Med., 1942, 42:1150.

# STATE ACTIVITIES

## NUTRITION IN EVERYDAY PRACTICE

S. WILLIAM KALB, M.D., Newark, N. J.
Nutrition Representative, Tuberculosis and Adult Disease Control Advisory Committee to the Subcommittee on Public Health

1. *Are vitamins indicated in patients who have a lowered metabolism?* Not unless other symptoms or signs are present. However, if thyroid therapy is given for lowered metabolism, the rise in metabolism from the thyroid usually produces a deficiency in $B_1$. It is therefore advisable to use thyroid and thiamine together when thyroid therapy is indicated.
2. *Which is utilized best—vitamin C, tomato juice or raw cabbage?* Tomato juice and raw cabbage are utilized by the body better than vitamin C tablets.
3. *I have used oil and ointments on patients for chapped skin without result. Is this due to any deficiency?* Usually vitamin A deficiency is present. Prescribe vitamin A 75,000 units per day for three weeks, then 50,000 units per day for two weeks, after which keep the patient on 25,000 units per day for four months.
4. *Does benzedrine inhibit the appetite by slowing up the tone of the digestive tract?* No. Its effect on the musculature of the stomach and intestines is slightly relaxing. It is a sympathetic stimulant and helps to dull the senses of sight, smell and taste. With the retardation of these senses the physical character of foods becomes less appealing.
5. *I have tried daily doses of 5,000 units of vitamin A in infantile eczema without any improvement. Is this dose inadequate?* Vitamin A is not the indicated vitamin. In infantile eczema there is a need for B complex. Use the Elixir Vitamin B Complex in doses of 2 to 4 teaspoonsful daily. Improvement will be noticed in two to four weeks.
6. *Do blood donors suffer from loss of iron?* The normal hemoglobin is 15 gm. per 100 ml. and has approximately 40 mg. of iron per 100 ml. of blood. Each pint of donated blood creates a loss of 200 mg. of iron. There is evidence that in regular donors there exists an hypochromic anemia (iron deficiency) especially if their diets do not meet the requirements of the Food and Nutrition Board which contain about 12 mg. of iron per day. It is therefore essential that "frequent donors" receive supplemental doses of iron.
7. *How much vitamin C is lost in cooking cabbage and in baking potatoes?*
   CABBAGE: 46 to 67 per cent is retained when using a pressure cooker, 30 to 34 per cent is retained in an open kettle.
   POTATO: 78 to 87 per cent is retained at 96° or 250° F. Overbaking for 20 minutes causes an additional loss of 6 per cent in the ascorbic acid content.
8. *Is oleomargarine as nutritious as butter?* Oleo has no nutritional value unless fortified with vitamin A.
9. *What causes the odor in onions?* Volatile sulfur.
10. *Do all brands of tomato juice have the same amount of vitamin C?* No. They may vary somewhat but in order to be acceptable they must contain 20 mg. vitamin C per 100 cc.

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES MEETING

The Annual Session of the House of Delegates of the American Medical Association will be held in Chicago, Illinois, from Monday, December 3, to Thursday, December 6, 1945.

OLIN WEST, *Secretary*,
American Medical Association.

## WORKMEN'S COMPENSATION

Daniel A. Spair, Director,
Workmen's Compensation Bureau, Trenton, New Jersey

A meeting of the Advisory Committee appointed by Commissioner of Labor Harry C. Harper to study Workmen's Compensation was held on September 12, 1945, in Newark. There was a general discussion on the medical phases of the Workmen's Compensation Act of New Jersey.

The meeting was attended by a number of physicians, including representatives of County Medical Societies and Dr. William K. Harryman, who is a member of the Committee. Dr. William Costello, another member of the Committee, was unable to be present because of illness. Dr. Costello has since indicated that he would like to be relieved, and in view of this request the Commissioner contacted Dr. Samuel Alexander, President of The Medical Society of New Jersey, asking for another name. Dr. Alexander recommended Dr. J. Irving Fort of Newark, and the Commissioner has appointed Dr. Fort in the place of Dr. Costello.

In a message to the Committee, Commissioner Harper requested that the following items be studied:

1. Should a full-time Medical Director be established in the Workmen's Compensation Bureau?
2. Should there be more medical examiners in the Workmen's Compensation Bureau, and what should be their duties?
3. Should there be any change in connection with allowances for fees for medical testimony?
4. Should we have a hospital and medical fee schedule for services under our Compensation Act?
5. What procedure can be established which will improve the present procedure in estimating permanent disability?

The items submitted by the Commissioner were fully discussed. There seemed to be general agreement that a Medical Director should be established in the Workmen's Compensation Bureau, but there were differences of opinion as to other items submitted by the Commissioner. An important item, insofar as the medical profession is concerned, is the question of a hospital and medical fee schedule in Workmen's Compensation matters. The present compensation act does not provide for the setting up of a fee schedule for doctors and hospitals. The law does provide that all fees and other charges for physicians' and surgeons' treatment shall be reasonable and based upon the usual fees and charges which prevail in the same community for similar physicians', surgeons' and hospital services. A fee schedule for certain hospital services has been established by agreement between representatives of the New Jersey Hospital Association and the representatives of insurance companies and self-insurers. The Commissioner of Labor has had a survey made as to medical fee schedules in other States and has submitted same to the Committee. The Committee will meet again on September 26, 1945, at which time these matters will be discussed with Deputy Commissioners and Referees of the Workmen's Compensation Bureau. After the Committee has completed its study, it will make recommendations to Commissioner Harper.

## THE AMERICAN COLLEGE OF CHEST PHYSICIANS

### NEW JERSEY FELLOWS—1945

The following physicians successfully passed the written examination for Fellowship in the American College of Chest Physicians held in June, 1945, and will be awarded their Fellowship Certificates at the next Convocation of the College:

David Biber, M.D., Union

Emanuel Klosk, M.D., Newark

The Convocations are held in conjunction with the annual meetings of the College which will be resumed in 1946.

# YEAR BOOK

## 1945 — 1946

## The Woman's Auxiliary

## to

## The Medical Society of New Jersey

### PROGRAM

As the Woman's Auxiliary to The Medical Society of New Jersey embarks upon another year of service, the picture of war has subsided but the ravages of war are still with us.

We, as Auxiliary members, have great responsibilities to the communities in which we live. One of the best contributions that can be made is to plan an active program. To this end, we are again sending each member a copy of the program for the year 1945-1946.

The purposes of this booklet are: first, to assist the various county chairmen in carrying out their work effectively; second, to act as a source of information for all members; and third, to suggest helpful means of accomplishing the aims of the various committees.

The Program Chairman expresses thanks to those who have furnished material for this booklet and at the same time, sincerely hopes that you will make good use of the information.

Do not allow that "now that the war is over" feeling to prohibit you from being active in your county work.

More than ever we are needed. Do not relax.

Make this year one to be remembered.

Mrs. Richard J. McDonald
777 Fourteenth Avenue
Paterson, N. J.

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### PRESIDENT'S MESSAGE

The immediate future of our nation depends upon what is done by every good American. As The Woman's Auxiliary to The Medical Society of New Jersey enters its nineteenth year of service, it behooves each member to apply her interest and energy to help make this a better world in which to live.

We are organized primarily to assist The Medical Society of New Jersey in such a manner as it may suggest or approve and to promote good fellowship among physicians' families.

We have been asked by The Medical Society to place great emphasis on our public relations with lay and other professional organizations, to keep them informed as to the work being done by The Medical Society of New Jersey through its Medical-Surgical Plan in bringing adequate medical care to a substantial number of persons in the low-wage group through voluntary health insurance.

We must continue our work in matters that affect legislation both in Washington and in Trenton. Many of our physicians will remain in service for some time to come. It is our obligation to welcome them home again to the practice of medicine which is free of politics.

There will be post-war problems affecting the returning medical officer and his family which the Woman's Auxiliary may help to solve.

During America's third war year—1944—New Jersey saw new health records set despite the additional health hazards of a people at war. By publicizing the reading value and the promotion of a wider distribution of Hygeia we can help maintain this high level.

The continuation of last year's success in securing members in the Society for the Relief of Widows and Orphans of Medical Men of New Jersey is earnestly requested. The Society in its 63rd annual report pays tribute to the Woman's Auxiliary for its efforts.

Efficiency in Auxiliary work can be acquired by subscribing for and reading the Bulletin, the official national publication of the Woman's Auxiliary. One of the aims of the current year is to increase the circulation of the Bulletin.

"Looking Ahead", we will return to our regular convention in 1946. As soon as convention facilities permit we should be prepared to resume the Art and Hobby Exhibit. With the return of our Medical Officers their biographies can be brought up to date.

Let us all work diligently to increase our membership, to encourage the interest of the public in the Medical-Surgical Plan of New Jersey, to accelerate the defeat of all obnoxious legislation, to facilitate the distribution of health information and to assist in the rehabilitation of returning physicians and their families.

My best wishes to you for a successful year.

Mrs. William E. Dodd
Ocean Street and Bay Avenue
Beach Haven, N. J.

## MESSAGE TO THE WOMAN'S AUXILIARY

World War II, having ended with victory for the Allied Forces, brings us face to face with the problems of the post-war era. These problems, affecting the members of The Medical Society and its Auxiliary, will be a challenge to all of us. The Woman's Auxiliary can play a very definite and constructive part in this program.

The major imminent problem will be to aid the returning physician and his family in their adjustment to civilian life and private practice. This may be difficult in some cases because the war has changed and broadened the viewpoint of many of our veterans. However, with patience, tact and understanding, I am confident the Auxiliary can be most helpful in meeting this requirement.

We are all familiar with the current agitation for some form of Federal control of medical practice. The Auxiliary, through the many contacts of its members with non-professional groups to which they belong, is in an excellent position to present the viewpoint of the physicians on the matter to a wide group.

I urge the State Auxiliary and each of its component groups to have active legislative committees. These committees, working with similar committees of the State and County Societies, will be very helpful in promoting good public health legislation.

The cause and treatment of cancer are rapidly arousing the interest of the public at large, and large sums of money have been collected to further these studies. The Auxiliary should take an active and prominent part in furthering this very worthwhile program.

There has never been a time when it was more necessary to present to the public our viewpoint on matters affecting public health through an active and intelligent public relations program. I have always felt that the people would be sympathetic to the physician's viewpoint if it could be properly presented to them. At your Auxiliary meetings, speakers should be invited to present this viewpoint so that your members could pass on to others the information concerning the constructive work being done by physicians.

We are very proud of the permanent home of the State Society and hope that the Auxiliary will make full use of it during the year.

The Officers of The Medical Society of New Jersey and our Office Staff offer you every cooperation and means of support. Please call upon us at any time if we can be of any assistance in reaching our mutual objectives.

Samuel Alexander, M.D., President,
The Medical Society of New Jersey.

## ORGANIZATION

During the war years it has been difficult for us to expand in number and strength, but with victory, we can expect to return to normal living in the near future. Let us then endeavor to make the Woman's Auxiliary strong, and do the things we have so long planned.

This can be accomplished by getting new members. Contact new doctors' wives, old members, and wives of men who have been in the service of our country. We need new blood and new ideas for our continued growth.

The Medical Society of New Jersey is the oldest Medical Society in this country, and each doctor's wife should consider it an honor and privilege to be an active member of her county auxiliary. Attend your meetings, and take other members with you who might not go alone.

Each county has its own special program and philanthropy, which are augmented by suggestions from both the State and National Auxiliaries. There is much to be accomplished, and it can only be done by a united effort on the part of each member. Let us make this a banner year in every way.

Mrs. J. Howard Hornberger
Brookside
Roebling, N. J.

## PUBLICITY

All reports for *The Journal* must be typewritten, double spaced. Reports and advance notices for *The Journal* must be in the hands of the State Chairman of Publicity by the 18th of each month. Advance notices handed in on the 18th should be those which are still to take place after the 15th of the following month; that is, future notices handed in on the 18th of April should be events which take place after the 15th of May.

Unless the meeting of the Auxiliary is of such standard as to warrant the presence of a reporter, the County Chairman of Publicity should send immediately following each meeting, a concise resume of events to the leading papers of her county. Advance notices of these meetings should be sent to the same papers a week preceding the meeting.

All notices pertaining to Auxiliary activity should be clipped and forwarded to the State Chairman of Publicity with the monthly reports.

Reports of the Auxiliary activities should likewise be sent to the official publication of the County Medical Society.

It is the duty of each County Chairman of Publicity to work at all times to increase the prestige of her Auxiliary in the community.

MRS. LODOVICO MANCUSI-UNGARO
156 Mt. Prospect Ave.
Newark, N. J.

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## LEGISLATION

The "preparedness" of Auxiliary members to aid in combatting vicious legislation will be put to the test this year. On May 24, 1945, Senator Wagner, for himself and Senator Murray, introduced in the United States Senate, a new bill (S-1050) amending the Social Security Act. An identical bill (HR 3293) was introduced in the House the same day by Congressman Dingell.

The bill is a book-length document of 185 pages covering every phase of social insurance. From 4 per cent employer and 4 per cent employee contributions on wages and salaries up to the first $3,600 per year and 5 per cent of the earnings of all self-employed persons up to the first $3,600 a year, would be produced an estimated eight billion dollars a year of which approximately $3,142,000,000 would be earmarked to provide Personal Health Services. These Services would be under the Surgeon-General, who would be thus established by law as the agent to dispense and pay for medical, dental, nursing and hospitalization services for an estimated 110 million people.

Since this new bill represents control over the most sacred and vital wants of every employed human being in this country, our Medical Society is vigorously opposed to the part of the bill referring to Personal Health Service. There are things we *must* do:

1. As Individuals, write to your Senator or Congressman requesting a copy of Senate Bill S-1050 or House Bill 3293. This will be sent without charge.

2. Also, as Individuals, write to the New Jersey Senators and the Congressman from your District expressing your opposition to the Public Health and Medical Practice features of these bills.

3. Offer your services to your Chairman of Legislation—we must be ready to act when our Medical Society instructs us to proceed.

4. Review our New Jersey Plans for (a) Hospitalization, (b) Medical-Surgical Care. We must be definite and accurate in all our statements. We must understand our platform and then not be afraid of our convictions.

This is an important year in Legislation. If we are not aware of this fact we shall deserve what Senator Wagner and his friends have in store for us. We must not be beaten by our own fears. We know beyond a shadow of a doubt that this bill is vicious with respect to Medical Care and we must be ready and willing to fight it.

Let us put first things first this year.

In the humble opinion of your Chairman of Legislation, this is a crucial year. She needs your help.

MRS. MAX L. WEIMANN
10 First Avenue
Haddon Heights, N. J.

## PUBLIC RELATIONS

Public Relations, which is the Auxiliary's informative contact with other professions and lay organizations, needs particularly this year to have a strong and workable program.

The Constructive Program for Medical Care of the American Medical Association appears in the August issue of the Bulletin and also in the July 21, 1945, A. M. A. Journal. It consists of fourteen points proposing a constructive schedule for the extension of improved health and medical care to all people. Acquaint your members with the program and use every possible effort to explain the platform to the public.

Let every Auxiliary member continue to oppose all un-American legislation including the New Wagner Bill S-1050.

Following is a list of suitable projects. Write me for material on any of them:

1. Promotion of Health Education.
2. Promotion of Child Health and Care.
3. Promotion of Authentic Nutrition Programs.
4. Promotion of Ideals of American Medicine. Its history, achievements, and aims.
5. Promotion of Nurses' Aide groups.
6. Practical help in solving post war problems, especially those affecting the returning medical officer and his family.
7. Program on Juvenile Delinquency.
8. Essay contest on health topics in public schools.
9. Devote one entire meeting to a Health Institute. Secure speakers from the State or County Medical Society and invite representatives of other organizations.

Should your group choose film service for schools and clubs, will you please keep in mind that these films should first be approved by our Advisory Committee if they are not those sent out from the Bureau of Education of the American Medical Association.

Proper evaluation of our efforts can be gauged by our publicity. Kindly send to your chairman all newspaper clippings, programs and reports concerning Public Relations.

Mrs. A. Lincoln Sherk
106 Browning Road
Merchantville, N. J.

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## POST-WAR MEDICAL PLANNING

Since the end of the war, post-war medical planning has entered the phase of attempting to put into operation studies and plans previously formulated.

Returning medical officers are vitally interested in plans concerning them. The Medical Society of New Jersey, in coöperation with the American Medical Association, has already made extensive studies and recommended certain plans.

The reports on these studies and plans are printed in The Journals of the A. M. A. and the State Society. The studies and plans include information on residencies in the various fields of medicine, refresher courses, and the relocation of physicians where needed and where the best opportunities are afforded. Studies were also made of the actual desires of the doctors returning to civilian life and the type of practice they wished to enter—general, special, group, industrial, etc. Every member of the Woman's Auxiliary should read the reports in The Journal.

The question arises, what can the Auxiliary do in the post-war planning for returning doctors? These plans are so well formulated that there is little we can do, except to have knowledge of such plans and to coöperate in any way the State Society requests.

Post-war medical planning has another phase that returning doctors are interested in, perhaps more now than before they entered the service. This phase is the future of American Medicine. The Wagner-Murray-Dingell Bill has been introduced in the Senate and House. It is a bill that if enacted, even with many changes, means the socialization of medicine.

Perhaps the Auxiliary can best serve the returning doctors and the American people by an aggressive educational program carried on through a coördinated program of the Public Relations and the Legislative Committees. Study groups should be formed so that women can keep intelligently alert concerning legislation affecting the conditions of the practice of medicine. It is generally accepted that the American people are satisfied with the quality of medical care they now have, but that they are not satisfied with the present methods of payment and distribution.

The Medical Society of New Jersey, through its Medical-Surgical Plan of New Jersey, offers the people a pre-payment plan for medical care, which in conjunction with the Hospital Service Plan of New Jersey, provides hospital and medical care under the control of medicine, hospitals and interested laymen. The pub-

lic must be made aware of the plans if we hope to defeat legislation tending to socialization.

War Service Program

The aid to Red Cross and the U. S. O., as outlined last year, must be maintained. Several thousand doctors and millions of our boys are still being processed for the occupation troops, in addition to those now serving overseas. It must be an all-out program and we must not let down in rendering every possible service until the occupation is complete and all of our forces are home.

Mrs. Gerald E. McDonnel
470 High Street
Mount Holly, N. J.

## BULLETIN

Our Woman's Auxiliary is a component of the Auxiliary to the American Medical Association and the Bulletin is one of our chief sources of information of the happenings of our organization throughout the United States.

The Bulletin is the official organ of the Woman's Auxiliary and contains information and material important to every doctor's wife. We firmly believe an Auxiliary member is a better member by reading the Bulletin. We also believe that once a subscriber, always a subscriber. For the small subscription rate of $1.00, no member can afford to do without the Bulletin.

The circulation of the Bulletin in our New Jersey Auxiliary represents a very small percentage of the membership. It is our aim this year to make more members readers of the Bulletin. We hope to at least double our subscriptions. Will you help us reach this goal?

Mrs. Floyd A. Shimer
88 Lewis St.
Phillipsburg, N. J.

## ARTS, HOBBY AND MEDICAL HISTORY

Each County Chairman should form an Arts, Hobby and Medical History Committee, made up of members representing the hospitals in that county. The various representatives will be able to handle the history of the particular hospital with which she is associated.

*Recommended Procedures for the Coming Year:*

a. Every county president shall appoint a chairman of Medical History, the latter to select a co-chairman in order to keep all data up to date.

b. The duty of the county chairman will be to collect material or data concerning physicians (such as state and county presidents), also biographies of deceased physicians who have contributed to scientific medicine; as well as physicians who claim a second or third generation in the medical profession.

c. A special section of the Medical History Scrap Book is to be kept for physicians who have served in World War II . . . each county recording its own group of men. Any information will be of importance, even if only newspaper clippings. Also included under this section will be physicians who have died in action, which will be of great importance for future reference.

*Information May be Secured from the Following:*

1. Hospitals in Each County — Heads of these hospitals should be interviewed and asked to coöperate in giving all information available concerning physicians who come under the above classifications. (In all biographies or write-ups, photographs of physicians should be included. They must be 2″x3″, and pasted in the upper right hand corner of page.)

2. Wherever possible, physician's widow or any other living members of the family of a deceased member may be asked to furnish all information they have or such material as old photographs, records of articles written by the deceased during his life, etc.

3. Another source is the Public Library. The librarian may be helpful in suggesting means of obtaining valuable information.

4. Clippings will be of great help in accounting for physicians returning from overseas duty.

*Suggestions for Recording All Information*

Two typed copies should be made of all data, one to be kept by the county chairman and the second to be sent to the state chairman

each month, so that a state record may be kept of the progress of each and every county.

All co-chairmen of every county should obtain a list of all available material for exhibit purposes. This will be of great importance when medical history exhibits are again resumed.

Collect old medical books, old instruments, records of the minutes of larger county meetings when state presidents or physicians have been guests, as well as old prescriptions, old photographs, historical medical pictures, etc.

Records of contributions made by each county to the 1942 convention will be most helpful.

Mrs. Samuel Jessurun
613 High St.
Newark, N. J.

## HYGEIA

Now that the war has terminated, the time has come for us to devote much more attention to the health problems of individuals and communities.

It is most important that authentic information on health be disseminated. Much information from various sources is inaccurate and definitely harmful. In order to counteract this, it is essential to place before the public, true facts. *Hygeia,* the health magazine of the American Medical Association, is a vital organ for so doing. It contains real health education, reliable information concerning nutrition, prevention of disease and maintenance of health, and advances in medical science. The articles are fascinating, written by prominent physicians and scientists. They are of a nature to interest everyone. In them, one is taught to recognize the danger signals of the body, how to work, play, and protect one's self from many diseases, and on the whole, how to lead a happier and healthier life.

It is my earnest desire to bring *Hygeia,* and the great value of placing it at the disposal of the general public, to the attention of all doctors' wives in the state.

Mrs. Samuel Alexander
Park Ridge, N. J.

## TREASURER

No organization can function without funds, so it is very important that this subject be carefully studied.

The fiscal year of each County Auxiliary shall be from February 1, to January 31 of the following year, and dues, with reports in triplicate, should be forwarded to the State Treasurer on February 1.

A complete list of suggestions and instructions (too lengthy to list here) will be mailed personally to each County Treasurer.

Mrs. Thomas P. McConaghy
S. W. cor. Tenth & Cooper Sts.
Camden, N. J.

## WIDOWS AND ORPHANS

Society of Widows and Orphans was organized for the purpose of affording economic benefits to widows and children of deceased members.

It is essentially not an insurance organization, but does provide for a death benefit; also financial assistance may be extended to the family of a deceased member, where it is warranted.

The greatest good to the greatest number can only be brought about by increase of membership in this Society.

All legally qualified practitioners of medicine in the State of New Jersey not over sixty-five years of age are eligible to membership.

Definite information regarding details as to application for membership and benefits which may accrue can be obtained by contacting your county chairman.

We hope that each member will do all in her power to increase the membership in this worthwhile organization.

Mrs. Charles F. Merrill
16 South Third Avenue
Highland Park, N. J.

## ARCHIVES AND HISTORY

To keep the past before us as an inspiration to greater works in the future, the histories and records are kept in the Archives.

Our program for the year 1945-1946 includes the following:

1. File all Archives material and look up necessary information whenever required.
2. Continue the work on the Presidents' Album, sample stationery folio, Annual Meeting booklet, and Memorial Book. Save monthly reports from *The Journal* to be used for News Book No. 2.
3. Send this year's County history to State Chairman for compilation of State Auxiliary history before the Annual Meeting.
4. Forward Medical Histories to State Chairman for the Archives.

Mrs. C. Chester Chianese
464 Hamilton Avenue
Trenton, N. J.

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## PARLIAMENTARY PROCEDURE SIMPLIFIED

Parliamentary Rules of Procedure are well established. Meetings conducted in an orderly and efficient manner add greatly to the order of business and the enjoyment of the programs. Prompt and regular attendance, constructive criticism, coöperation and willing service are essential points to keep in mind.

The following outline is merely a suggestion given in the spirit of coöperation.

Business transacted at a regular meeting of the Auxiliary usually follows the order below:

1. Call to order.
2. Reading of the minutes and the approval.
3. Treasurer's statement.
4. Reading of communications by the Corresponding Secretary.
5. President's Report. Vice-President takes the chair and asks for a motion to accept the President's report with thanks. (Complete motion.)
6. President may ask for a motion at the completion of the reading of the following reports that they be accepted as a whole; someone moves and someone seconds the motion that the reports be accepted as a whole, the vote is cast.
   a. Officers' Reports.
   b. Standing Committees' Reports.
   c. Special Committees' Reports—recommendations suggested by all Committees will come up under New Business.
7. Unfinished Business.
8. New Business.

Recommendations—The Chairman of the Committee presents the recommendation to the group. The Chairman may move the adoption of the recommendation, a member seconds the motion; following discussion the motion is voted upon—all in favor or opposed. The President states the recommendation is accepted or lost. The President then thanks the Chairman and her Committee which is automatically discharged.

The President says the pending motion to accept the reports is next in order, all in favor say aye, opposed no, the motion is carried.

9. Announcements.
10. Program.
11. Adjournment.

Mrs. Don A. Epler
45 Hillside Avenue
Newark, N. J.

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## NOMINATIONS

The Nominating Committee is desirous of hearing from the various component County Auxiliaries, the names of any of their members who they feel will be eligible for membership on the Executive Board of the State Auxiliary.

The membership of each County is, of course, more familiar with the respective abilities of its members, and it is only through your coöperation that our Executive Board can be as efficient and as representative as it should be.

Mrs. David B. Allman
104 St. Charles Place
Atlantic City, N. J.

## OFFICERS

*President*
MRS. WILLIAM E. DODD
Ocean Street and Bay Avenue, Beach Haven

*President-Elect*
MRS. FREDERICK G. WANDALL
50 East High Street, Clayton

*First Vice-President*
MRS. LODOVICO MANCUSI-UNGARO
156 Mt. Prospect Avenue, Newark

*Second Vice-President*
MRS. FLOYD A. SHIMER
88 Lewis Street, Phillipsburg

*Recording Secretary*
MRS. BANKS S. BAKER
618 Benson Street, Camden

*Corresponding Secretary*
MRS. EMANUEL M. SICKEL
318 Forest Avenue, Lakewood

*Treasurer*
MRS. THOMAS P. MCCONAGHY
Tenth and Cooper Streets, Camden

### DIRECTORS

MRS. JAMES H. MASON ..... Ventnor
MRS. ANDREW C. RUOFF ..... Union City
MRS. FRANK A. BIEN ..... New Vernon
MRS. SAMUEL ALEXANDER ..... Park Ridge
MRS. C. CHESTER CHIANESE ..... Trenton
MRS. ROBERT B. WALKER ..... Highland Park

### ADVISORY BOARD

MRS. RICHARD J. MCDONALD ..... Paterson
MRS. OSWALD R. CARLANDER ..... Audubon
MRS. J. HOWARD HORNBERGER ..... Roebling
MRS. ASHER YAGUDA ..... New York City
MRS. DAVID B. ALLMAN ..... Atlantic City

### HONORARY MEMBER

DR. CLARA C. RENNER ..... Blawenburg

### NATIONAL PRESIDENT

MRS. DAVID W. THOMAS
112 W. Main Street, Lock Haven, Pa.

### FELLOWETTES

The Fellowettes are the Past Presidents of the Woman's Auxiliary.

| | | |
|---|---|---|
| 1927-28 | MRS. A. HAINES LIPPINCOTT | Camden |
| 1928-29 | MRS. GEORGE L. ORTON | Rahway |
| *1929-30 | MRS. JAMES HUNTER | Westville |
| 1930-31 | MRS. JOHN NEVIN | Jersey City |
| 1931-32 | MRS. H. ROY VAN NESS | Newark |
| 1932-33 | MRS. CHARLES F. ADAMS | Trenton |
| 1933-34 | MRS. HARRY V. HUBBARD | Plainfield |
| 1934-35 | MRS. ARTHUR J. CASSELMAN | Camden |
| *1935-36 | MRS. FREDERICK A. KINCH | Westfield |
| 1936-37 | MRS. GEORGE A. ROGERS | East Orange |
| 1937-38 | MRS. SAMUEL L. SALASIN | Atlantic City |
| 1938-39 | MRS. DON A. EPLER | Newark |
| 1939-40 | MRS. GERALD E. MCDONNEL | Mount Holly |
| 1940-41 | MRS. RICHARD J. MCDONALD | Paterson |
| 1941-42 | MRS. OSWALD R. CARLANDER | Audubon |
| 1942-43 | MRS. J. HOWARD HORNBERGER | Roebling |
| 1943-44 | MRS. ASHER YAGUDA | New York City |
| 1944-45 | MRS. DAVID B. ALLMAN | Atlantic City |

* Deceased.

### CALENDAR, 1945-1946

October 8, 1945 ..... Trenton
January 14, 1946 ..... Trenton
March 11, 1946 ..... Trenton
May 21, 22 and 23, 1946—
Annual Meeting ..... Atlantic City
All County Auxiliary Members are invited to all State Meetings.

### COUNTY PRESIDENTS

*Atlantic* ..... MRS. ROBERT A. BRADLEY
2 S. Brunswick Avenue, Margate

*Burlington* ..... MRS. E. VERNON DAVIS
214 High Street, Mount Holly

*Camden* ..... MRS. REUBEN L. SHARP
Springdale Road, Fellowship

*Essex* ..... MRS. S. BERNARD KAPLAN
32 South Munn Avenue, East Orange

*Gloucester* ..... MRS. FREDERICK J. FAUX
32 N. Columbia Street, Woodbury

*Hudson* ..... MRS. EDWARD A. MURPHY
45 Highland Avenue, Jersey City

*Mercer* ..... MRS. H. DONALD COWLBECK
110 Morningside Drive, Trenton

*Middlesex* ..... MRS. CHARLES F. MERRILL
16 S. Third Avenue, Highland Park

*Monmouth* ..... MRS. THOMAS H. ANDREWS
111 Main Street, Matawan

*Ocean* ..... MRS. CARL H. MENGE
226 Washington Street, Toms River

*Passaic* ..... MRS. JOSEPH E. MOTT
426 Park Avenue, Paterson

*Somerset* ..... MRS. LANCELOT ELY
128 W. High Street, Somerville

*Union* ..... MRS. HARRY V. HUBBARD
121 E. Seventh Street, Plainfield

*Warren* ..... MRS. FLOYD A. SHIMER
88 Lewis Street, Phillipsburg

### COUNTY MEETINGS

Atlantic—2nd Friday, October through May; Annual Meeting, May.
Burlington—1st Monday, October through May; Annual Meeting, May.
Camden—1st Tuesday, October, January, March; Annual Meeting, May.
Essex—4th Monday, October through May; Annual Meeting, May.
Gloucester—3rd Thursday, October through May; Annual Meeting, May.
Hudson—1st Monday, October through May; Annual Meeting, April.
Mercer—2nd Monday, November, January, February, April; Annual Meeting, May.
Middlesex—3rd Wednesday, October through June; Annual Meeting, December.
Monmouth—1st Wednesday each month; Annual Meeting, April.
Ocean—1st Friday, October through May; Annual Meeting, May.
Passaic—3rd Monday, October, January, March; Annual Meeting, May.
Somerset—2nd Thursday, October, December, February, April; Annual Meeting, June.
Union—2nd Wednesday, September, November, January, March, April; Annual Meeting, May.
Warren—3rd Tuesday, October through May; Annual Meeting, March.

## BOOKS RECEIVED FOR REVIEW

TREATMENT IN GENERAL PRACTICE. By Harry Beckman, M.D. 5th ed. Pp. 1070, illustrated. Philadelphia & London, W. B. Saunders Company. 1945. $10.00.

DISEASES OF THE BREAST. By Charles F. Geschickter, M.D. 2d ed. Philadelphia, J. B. Lippincott Company. 1945. $12.00.

NEW GOALS FOR OLD AGE. Ed. by George Lawton. Pp. 210. New York, Columbia University Press. 1944. $2.75.

COMMON AILMENTS OF MAN. Ed. by Morris Fishbein, M.D. Pp. 177. New York, Garden City Publishing Company. 1945. $1.00.

ESSENTIALS OF CLINICAL ALLERGY. By Samuel J. Taub, M.D. Pp. 198. Baltimore, Williams & Wilkins Company. 1945. $3.00

RISE OF THE TYRANT; Controlled Economy versus Private Enterprise. By Carl McIntyre, Pastor of the Bible Presbyterian Church, Collingswood, N. J. Pp. 260. Collingswood, New Jersey, Christian Beacon Press. 1945. $2.25.

MEN UNDER STRESS. By Roy R. Grinker, Lt. Col., M.C., and John P. Spiegel, Major, M.C., Army Air Forces. Pp. 484. Philadelphia, The Blakiston Company. 1925.

ONE HUNDRED YEARS OF GYNECOLOGY, 1800-1900. By James V. Ricci, A.B., M.D. Pp. 651. Philadelphia, The Blakiston Company. 1945. $8.50.

## BOOK REVIEWS

**Allergy in Practice.** By Samuel M. Feinberg, M.D., with the collaboration of Oren C. Durham. Pp. 798. Chicago, Year Book Publishers, Inc. 1944. $8.00.

This text is a comprehensive and sincere reference book for the physician who seeks sound and simplified information in the field of allergy.

It is necessarily a large volume but has the virtue of direct and thorough discussion of basic principles, the many allergic states and their management. The reader is left with the feeling that while familiarizing himself with the material will not create in him an allergist, it will nevertheless give him a comfortable understanding and skill in the handling of the allergic in routine medical practice.

The chapter devoted to fungi is especially remarkable for its rich information. It evokes the realization that the author has unusual interest and knowledge of these badly neglected allergens. In no other work dealing with fungi, as disease agents, are fungi and their allergic significance adequately detailed.

The many manifestations, recognition and treatment of allergy secondary to inhalants, bacteria, food, drugs, etc., are in turn treated with a satisfying exhaustiveness.

Each chapter is completed by a pithy and neat review, while invaluable lists and charts are scattered throughout the pages.

One comes to the final chapters of this book with a bright, unconfused, rather than a discouraged attitude toward his next allergy problem, particularly since he will resolve, no doubt, to place this volume among his standard reference books.

E. Z. MERRICK, M.D.

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**Practice of Medicine.** By Jonathan Campbell Meakins, M.D., LL.D. 4th ed. Pp. 1444 with 517 illustrations including 48 in color. St. Louis, The C. V. Mosby Company. 1944. $10.00.

This latest revision brings one of the more recent text-books on the practice of medicine as up to date as any text-book can ever hope to be. Recent advances in chemotherapy with the newer sulfonamides and penicillin are adequately discussed and incorporated in their proper chapters. Many old and newer syndromes are more thoroughly discussed on the basis of their increasing incidence as a result of military medicine and the invasion of our troops into heretofore remote island outposts with their individual tropical or endemic infections and disorders.

While no revolutionary changes have been necessary in revising this book, the present revision keeps it in the forefront as one of the best text-books designed primarily for students of medicine and general practitioners.

ARTHUR J. D'ALESSANDRO, M.D.

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**Control of Pain in Childbirth:** Anesthesia, Analgesia, Amnesia. By Clifford B. Lull, M.D., F.A.C.S., and Robert A. Hingson, M.D. Pp. 356 with 100 illustrations in black and white and 32 subjects in color. Philadelphia, J. B. Lippincott Company. 1944. $7.50.

This is a very serious and honest book. It is, of course, impossible even to enumerate all of its highlights. We can just point out a few of them. For instance, chapter four on the "Psychology and Management of Labor" is in itself a compilation of valuable knowledge.

It is well known that the authors have revived and improved cauõal anesthesia, but this book does not try to stress their own method. It is critical and gives an analysis of all possible methods applied to the various situations and conditions in obstetrics. What they really do stress is the art of anesthetics in obstetrics; also the need for a method of pain relief with the smallest possible toxicity, "a method which, when properly administered absolutely protects from transplacental intoxication". There should always be oxygen available and it should be resorted to while the cord is pulsating.

Very significantly we find a passage appealing to one of the accoucheur's foremost functions: to conserve the mother's blood "it seems to be a trivial statement, but if we look around, we think many a

blood transfusion could be avoided if this rule would be observed more strictly". This fact has been getting more and more important ever since we learned about immunization states after transfusions becoming permanent and able to cause heavy reactions even many years thereafter.

The authors are excellent teachers, as may be seen by the many diagrammatic illustrations and the summaries. This is a timely monograph, one that the obstetrician as well as the anesthetist will read with great advantage.

HERBERT STEINER, M.D.

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**Clinical Heart Disease.** By Samuel A. Levine, M.D., F.A.C.P. 3d ed. Pp. 462 with 157 illustrations. Philadelphia & London, W. B. Saunders Company. 1945. $6.00.

The third edition of Clinical Heart Disease brings this subject up to the last minute for the general practitioner. The easy narrative style the characterizes the first two editions is maintained throughout the present volume, and a few pages read at the end of a strenuous day are relaxing rather than exhausting.

The book opens with a full discussion of all the ramifications of rheumatic fever, and progresses through the various valvular lesions, the pericardial diseases and the extensive problem of coronary disease. Hypertension and thyroid disease are fully covered. Great stress is laid on the differential points in the diagnosis of the arrythmias. Throughout these chapters, emphasis is laid on the clinical features in the diagnosis and treatment.

Newer developments in heart disease claim a prominent place in the book. The chemotherapy of subacute bacterial endocarditis and the surgery of patent ductus arteriosis are examples of the new subjects that receive prominent mention. The chapter on electrocardiography has grown considerably, great emphasis being laid on the importance of the precordial lead. A brief chapter on the medico-legal aspect of heart disease intrigues the reader with the possibilities this field presents in the exercise of one's honest judgment in the light of the newer thought on the development of cardiac pathology, and the prognosis of many types of heart disease. The elaboration of this chapter in future editions will no doubt be a feature worth looking for.

CHARLES HYMAN, M.D.

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**Textbook on Pathology of Labor, the Puerperium and the Newborn.** By Charles O. McCormick, A.B., M.D., F.A.C.S. Pp. 399 with 191 illustrations including 10 in color. St. Louis, The C. V. Mosby Company. 1944. $7.50.

The appalling fact that stillbirth and neonatal death still are preponderantly obstetrical would be reason enough to write such a book, that in fact is the result of many years of teaching experience. We still need more education just as in the days of the tragic Semmelweis. That is why the author stresses the proper handling of the puerperium and the many so-called "smaller" obstetrical operations. Just as the late Schauta used to say: "Gentlemen don't minimize normal labor."

The pelvic measurements should be taken with painstaking accuracy, those concerning the pelvic outlet particularly; the use of x-ray pelvimetry is suggested too, of course. One can only mention the didactic value of the many excellent chapters on technique and treatment of all sorts of everyday worries of the obstetrician, that are pathologic. There is the warning to do Kristeller's expression more gently; the statement to use one forceps "which one is thoroughly familiar with rather than to possess several applicable to various conditions". There is also the warning that we had better diagnose breeches at the proper time. I would not agree with the author's admonition to convert breeches into cephalic presentations since the permanent results are not very encouraging.

This book is written right to the point; it gives the fundamentals in a comprehensive form, it is unconventional in style and concept which is much to its advantage; it is stimulating, and after reading it one wonders whether routine examinations should not be extended to x-ray pelvimetry and the determination of the Rh factor of both parents.

The student, the intern, the resident and the practitioner may use this textbook to great advantage.

HERBERT STEINER, M.D.

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**Trauma in Internal Disease:** With Consideration of Experimental Pathology and Medico-legal Aspects. By Rudolf A. Stern, M.D. Pp. 575. New York, Grune & Stratton. 1945. $6.75.

Almost the entire field of internal medicine in its relationship to external non-perforating trauma is presented except the effects of injury upon diseases of the nervous system, joints, electrical injuries and chronic poisoning. Included are medico-legal aspects and countless illustrative case reports as well as experimental data. It is a colossal presentation dedicated to a master pathologist, the beloved Francis Carter Wood, "with admiration and gratitude". In the foreword by Dr. Wood a keynote is struck—"There is no field of medicine that presents so many obscure phases or in which it is so difficult to form sound opinions on a scientific basis as that of traumatically caused internal diseases".

Court decisions are usually based on opinions of testifying physicians. These opinions must reflect mature experience and pertinent, extensive knowledge.

This reviewer is particularly interested in those sections dealing with surgical topics relating to appendicitis and peptic ulcer. Dr. Stern quotes a study of 15,568 cases. The incidence of trauma was found to be .3 per cent in adults and .4 per cent in children. Due skepticism should, therefore, be observed. It is noted that the older generation of surgeons expresses greater conservation concerning the cause and effect mechanism of trauma than does the present generation. It is but common sense to express an opinion with extreme caution concerning the primary relationship of external trauma to appendicitis because one never knows what the condition of the appendix was prior to the injury. The pertinent question is not whether

trauma can originate an attack of appendicitis or whether its effect is that of lighting up a dormant lesion, but it is emphatically whether or not trauma can precipitate a clinical attack of acute appendicitis. It can, and the lesion is apt to be the obstructive type.

The author deals quite adequately with trauma and peptic ulcer. The effects of direct, blunt, abdominal force, head injury and traumatic neurosis indirectly, are appropriate topics and are subject to even greater skepticism than is traumatogenic appendicitis. It is, therefore, incumbent upon the expert who appears in court to conduct a fact-finding inquiry and to present his conclusions after careful analysis.

This book is heartily recommended to those interested in the medico-legal aspects of trauma and disease. Royal H. Fowler, M.D.

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**Textbook of Pathology:** Pathological Anatomy in Its Relation to the Causes, Pathogenesis and Clinical Manifestations of Disease. By Robert Allan Moore. Pp. 1338 with 513 illustrations, 34 in color. Philadelphia & London, W. B. Saunders Company. 1944. $10.00.

For a long time pathologists have endeavored to classify diseases on an etiological basis. Dr. Moore, in his textbook of pathology, has come nearer to this ideal than anyone has done heretofore. He correlates the morbid changes in the tissues with disturbances in metabolism. These are accompanied by a large number of beautiful gross photographs and photomicrographs in black and white and in natural color, where applicable. This book covers general pathology and special pathology. Historical facts are admirably brought out. There is an ample bibliography after each chapter.

In addition to clearly describing pathological changes that take place in the body, with their causes, Dr. Moore cites illustrative cases in a clear and concise manner. This makes the volume extremely valuable both to the practitioner and to the student. S. A. Goldberg, M.D.

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**Constitution and Disease:** Applied Constitutional Pathology. By Julius Bauer, M.D. 2d ed. Pp. 247. New York, Grune & Stratton, Inc. 1945. $4.00.

It has been a pleasure and a privilege to read this second edition of Professor Bauer's book. He is a pioneer in the study and research of applied constitutional pathology as related to genetics. The book, although comparatively small, contains abundant material which demonstrates clearly the rôle played by pathological genes in producing and transmitting abnormal constitutional traits and disease syndromes.

Due consideration is given to environmental and psychological conditions, nutritional states and true endocrine diseases and so-called endocrinopathies. Attention, however, is drawn to the fact that endocrines, vitamins and allergins are being depended on as therapeutic agents by present-day clinicians to the exclusion of more profound consideration of hereditary constitutional factors.

For instance: Tendency to allergic states is transmitted as a dominant hereditary characteristic; primary dysmenorrhea occurs chiefly in persons with a neuropathic constitution, persons with a hypersensitive nervous system. The above are examples of hereditary abnormal constitution, or the so-called constitutional inferiority.

"Status degenerativus" is a term coined by Prof. Bauer many years ago; it comprises all types of abnormal constitution and a morbid predisposition to disease. Neuropaths, asthenics, persons exhibiting a tendency to exudative or allergic diatheses or endocrine stigmatization belong in that group.

The broader concept of constitutional anlage of certain diseases and tendencies to physical and psychogenic disturbances tends to enlarge the scope of therapeutic measures. Besides the current therapeutic measures indicated, susceptible persons should be placed in more favorable environmental conditions and be given proper supervision as far as diet, and physical and mental hygiene are concerned. Thus, through a better understanding of normal and abnormal constitution, the clinician may be better equipped to deal with certain diseases and disease tendencies.

This book is a valuable and timely contribution to the science and practice of medicine.

Rita S. Finkler, M.D.

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**New Goals for Old Age.** Ed. by George Lawton. Pp. 210. New York, Columbia University Press. 1944. $2.75.

From the first chapter, a psychiatrist's view of adjustment over the life span, to the last, in which an anonymous contributor tells, with wisdom, humor and charm, how it feels to be seventy-five, the volume is packed with suggestions as to the capabilities of older people as well as their limitations, their relation to the community as well as to the family, and their potential contribution to our society as well as their demands upon it.

Social workers, psychologists, administrators of old-age assistance, and others who work with the elderly have come to realize that old people have resources for useful, happy living which are almost untapped today. This book, which sets forth some of the more recent ideas concerning the nature and needs of older people, is a stimulating expression of this new point of view.

Whether you are professionally concerned with the care of the aged or personally troubled about the problems of older members of your family, whether you are already faced with the difficulties of old age or merely apprehensive as to what it may have in store, this book will prove of interest.

Carolyn Valentine, B.S.

# Tuberculosis Abstracts

*A Review for Physicians*

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

**Vol. XVIII** **October, 1945** **No. 10**

THE tuberculin test, on which much of the early work in tuberculosis was based, came into serious question when significant numbers of tuberculin negative reactors were found to have pulmonary calcification suggestive of tuberculous infection.

The evidence now accumulating indicates that calcification is a non-specific response of lung tissue to invasion, and may be called forth not only by the tubercle bacillus but by *Histoplasma capsulatum*, *Coccidioides immitis*, and perhaps other organisms. Tuberculin testing, therefore, takes again its rightful place as a biological test for the presence of the tubercle bacillus, while chest X-rays complement but do not supplant it as a diagnostic procedure.

## NONTUBERCULOUS PULMONARY CALCIFICATION AND SENSITIVITY TO HISTOPLASMIN

In different parts of the country, there are marked variations in the frequency of pulmonary calcification observed in roentgenograms of the chest. Recent studies have shown that the prevalence of calcified lesions varies from six per cent in Oregon to 28 per cent in Kentucky. An area of high prevalence occurs in the East Central States, with a frequency generally lower in surrounding regions. Roentgenographic findings have been the basis for rejecting appreciable numbers of persons from the armed services.

Although pulmonary calcification is usually considered evidence of healed tuberculosis, there are strong indications that this disease is not the only important cause of such lesions. The correlation between the prevalence of tuberculosis and the frequency of calcification is not close, and a number of reports have shown that in the area of high rates of calcification, a large proportion of the persons with such lesions have negative tuberculin reactions. It has been shown repeatedly that reversion from tuberculin positive to negative takes place very slowly, and that calcifications exist in tuberculin negative children. These facts have led to a search for nontuberculous origins of the lesions, especially among the fungi. Ascariasis, as a cause of pulmonary calcification in man, has not been proved of significance. In the Southwest, coccidioidomycosis accounts for some calcification. Because the endemic area of clinical histoplasmosis corresponds with the area of high prevalence of pulmonary calcification in tuberculin negative reactors, a possible association has been sought.

The question of tuberculin negative pulmonary calcification has been studied recently in an extensive investigation on tuberculosis in student nurses, which is being conducted cooperatively by the National Tuberculosis Association, the U. S. Public Health Service, and a large number of specialists throughout the country. About 10,000 student nurses are under close observation, and are given tuberculin tests and 14″ x 17″ chest X-rays at six-month intervals. The schools are sixty-five in number, and are located in nine widely distributed metropolitan centers. Results from the study bring out clearly the regional differences in the frequency of pulmonary calcification, as well as the fact that especially in the East Central part of the country, the majority of nurses with calcification have negative tuberculin reactions.

In order to investigate the possibility that infection with *Histoplasma capsulatum* may be a cause of pulmonary calcification, a large number of nurses were given intradermal histoplasmin tests. Preliminary data are based on records of these tests, roentgenograms, and tuberculin tests of 3,105 student nurses in four centers. Results of

this work indicate that (a) infection with histoplasma, or an immunologically related organism, is common in widespread localities, and that (b) it is probably the principal nontuberculous cause of pulmonary calcification. These conclusions are based on the assumption that skin sensitivity to the histoplasmin used in this study is indicative of infection with *Histoplasma.*

All skin tests were performed and read by one person, and all films were interpreted by one experienced roentgenologist. Film findings are limited to a report as to the presence or absence of shadows characteristic of calcification in the lung parenchyma or lymph nodes. The interpretation was recorded without knowledge of the tuberculin reaction and prior to the testing with histoplasmin.

Most of the nurses tested were given tuberculin and histoplasmin at the same time, and measurements of both erythema and induration were recorded at 48 hours. The reactions to the two tests were similar and could not be distinguished by their appearance.

Of the 3,105 nurses studied, 711 (22.9 per cent) showed a positive reaction and 61 (2.0 per cent) a doubtful reaction to histoplasmin. Great differences were found in the percentage of nurses reacting to histoplasmin in the various cities. In Minneapolis and St. Paul, the percentage of definite or doubtful reactions was 6.3; in Philadelphia, 12.6; in Detroit, 14.4; in Kansas City, Kansas, 54.0; and in Kansas City, Missouri, 65.8.

The most striking findings in the investigation are derived from the study of the relation, in individual nurses, between pulmonary calcification and reaction to histoplasmin and tuberculin tests.

About one-fifth (21.4 per cent) of the total group of 294 nurses with calcification had a positive tuberculin. Of the remaining four-fifths (231), who had a negative tuberculin, 206 had a positive or doubtful histoplasmin reaction. Only 25 nurses (8.5 per cent of the 294 with calcification) had a negative reaction to both tests. From these findings it may be seen that a high proportion of the group having pulmonary calcification react to histoplasmin, tuberculin, or both (91.5 per cent), and that many more react to histoplasmin than tuberculin.

Of the nurses who react only to the latter, 10.4 per cent show pulmonary calcification, while of those reacting only to histoplasmin, 31.1 per cent show calcification. A very low rate of pulmonary calcification (1.2 per cent) is found among the large group of 2,141 nurses who are negative to both tests.

Perhaps it is premature at the present time to discuss the significance of the general findings presented in this paper. If the histoplasmin test is corectly interpreted, however, a number of implications become apparent. Histoplasmosis, in a mild, perhaps subclinical form, may be a common infection in the East Central States, and the number of persons attacked may total several million. The epidemiological evidence indicates that a high proportion of the pulmonary calcification observed in individuals living in these States may be due to infection with *Histoplasma* or a related organism, and not to tuberculosis.

*Nontuberculous Pulmonary Calcification and Sensitivity to Histoplasmin, Carroll E. Palmer, M.D., Public Health Reports, Vol. 60, p. 513, May 11, 1945.*

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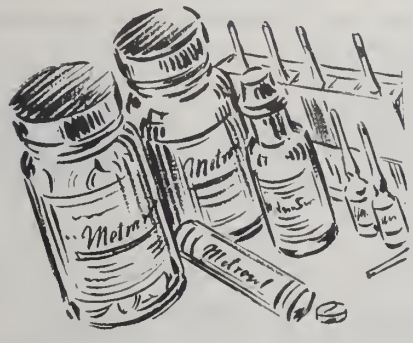
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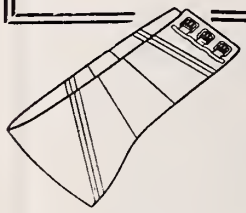
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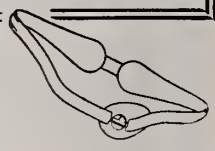
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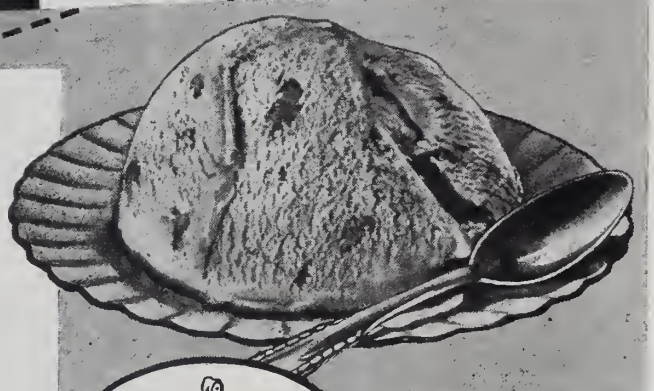
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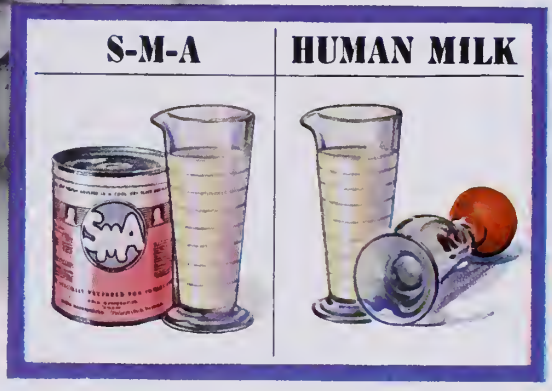
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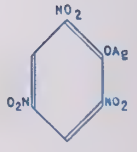

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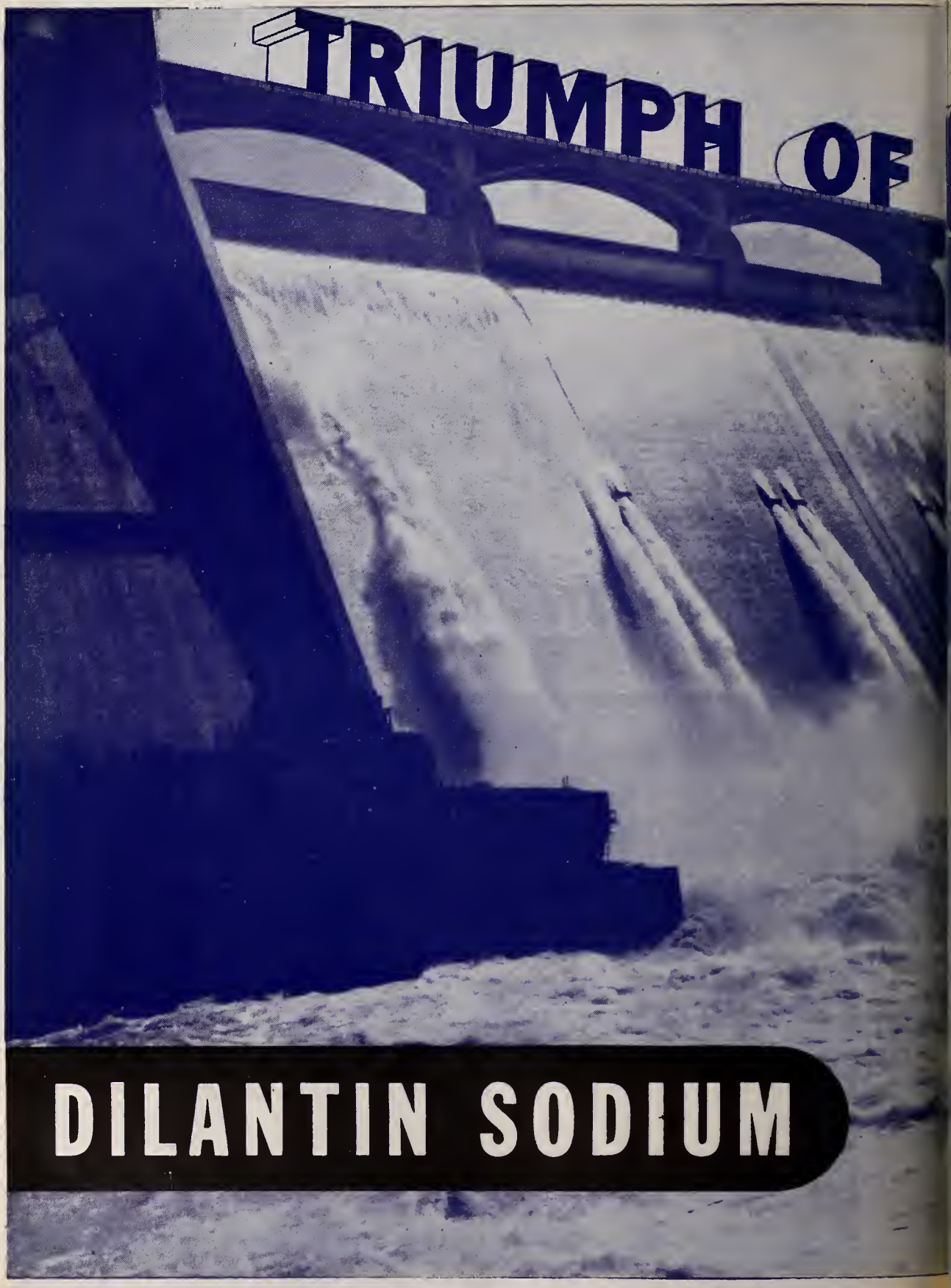
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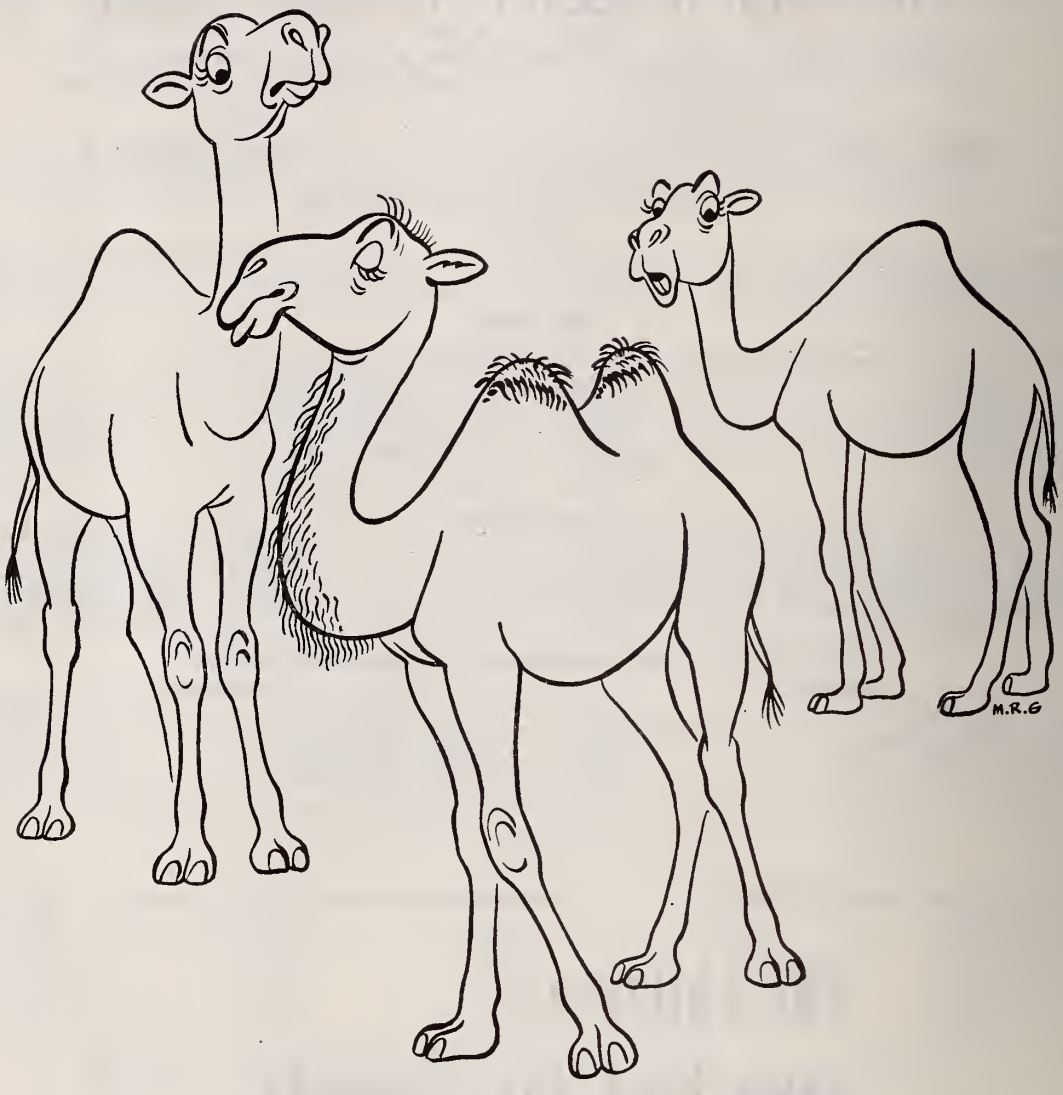
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COMES THE CRY of the leadsman from his point on the bow, "By the deep, six"—safe water. Continuous soundings safeguard the course of a vessel in fog and in shallow channels . . . a final check against instruments and navigators' calculations.

For more than sixty-nine years Eli Lilly and Company has sought to safeguard the interests of the physician and to strengthen his position as a health factor by providing, in an ethical manner, medicinal agents of quality unexcelled. A "Lilly" specification on your prescription guarantees your patient the finest medication the markets of the world afford. Available through prescription stores everywhere.

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FEW DISEASES have exercised a more profound influence on the lives of civilized people than smallpox. Once a dreaded scourge, the disease is now confined to sporadic outbreaks. Since immunity is developed in approximately eight to ten days after successful vaccination, it is possible to vaccinate contacts promptly after exposure and to prevent, or at least attenuate, the disease. Smallpox Vaccine, Lilly, is available in packages containing 1 immunization (V-1) and 5 immunizations (V-5), complete with rubber bulb for ejecting, and individually sealed, sterile needles for scarifying. Available through your regular source of medical supplies.

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IT IS OF VITAL IMPORTANCE TO THE PATIENT'S FUTURE APPEARANCE THAT THE FIRST ARTIFICIAL EYE BE PROPERLY FITTED. IT IS IN THESE NEW CASES, WHERE UTMOST ATTENTION MUST BE GIVEN—AND OF WHICH WE HAVE MADE A SPECIAL STUDY.

Especially Made to Order Eyes by Skilled Artisans.

Also Eyes Fitted from Stock.

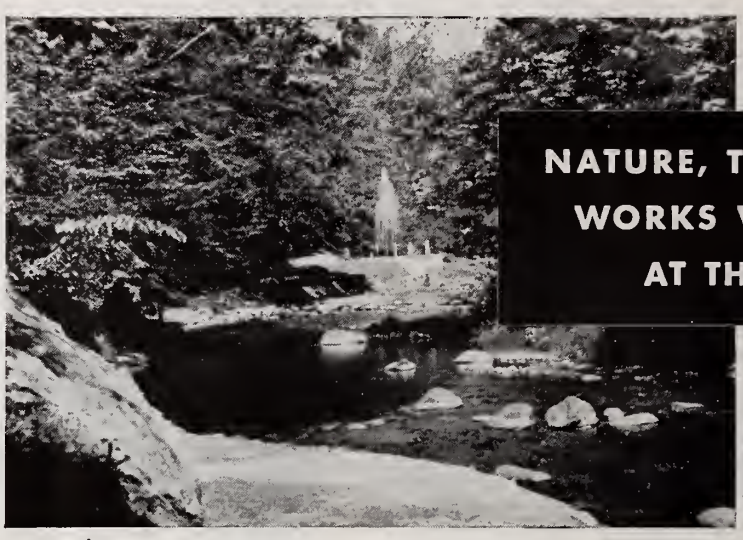
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*"Pleasing Particular People for Over Forty Years!"*



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The superb man-made facilities at the Saratoga Spa are placed in a setting of great natural beauty. In this serene environment a sick person is ideally prepared for the full benefit of medical care.

Here your patient is relaxed in both mind and body, so that the therapeutic values of the Spa's naturally carbonated mineral waters are enabled to exert their maximum efficacy.

Your patient suffering from such conditions as cardiac, vascular or rheumatic disorders receives the benefit of the Spa's restorative powers under a regimen of treatment which you yourself recommend.

Well trained physicians are available in Saratoga Springs for consultation with your patient on the details of the program.

With your patient at the Spa, you find needed relief from postwar strain in the knowledge that your directions for his continuing care will be faithfully carried out.

## THE SARATOGA SPA

**"PHYSICIAN, GIVE HEED TO THINE OWN HEALTH"**

Many physicians have recently come to the Spa for the same kind of treatments that helped their patients here. After a restorative "cure" at the Spa, you, too, would return to your practice refreshed—revitalized—ready for the busy days that still lie ahead.

**THE EMPIRE STATE'S CONTRIBUTION TO THE MEDICAL PROFESSION**

*For professional publications of the Spa, and physician's sample carton of the bottled waters, with their analyses, please write W. S. McClellan, M. D., Medical Director, Saratoga Spa, 159 Saratoga Springs, N. Y.*

No appreciable ciliary inhibition . . . Benzedrine Inhaler causes "no appreciable change in the amplitude or rapidity of the ciliary beat." Proetz, A.W.: Arch. Otolaryng., 30:509.




In addition, Benzedrine Inhaler, N. N. R., does not give rise to any significant degree of secondary turgescence, atony or bogginess, when used as directed.

The Inhaler is strikingly effective in reducing the congestion accompanying head colds, hay fever, and sinusitis. Each Benzedrine Inhaler is packed with racemic amphetamine, S. K. F., 200 mg.; menthol, 10 mg.; and aromatics. Smith, Kline & French Laboratories, Phila., Pa.

Benzedrine Inhaler

a better means of nasal medication

ACCEPTED AMERICAL MEDICAL ASSN.

***WHEN*** *digestive symptoms and general malaise are accompanied by marked downward displacement of the viscera, they are often relieved by* ANATOMICAL SUPPORT.




*X-Ray of patient with visceroptosis. (Left) The lesser curvature of the stomach is below the crests of the ilia. (Right) X-Ray of same patient after application of Camp Support for visceroptosis indicating how the viscera is held in a more nearly normal position.*

# Visceroptosis Support – CAMP

The roentgenologist may or may not find disturbed conditions in the duodenum... the displaced viscera being the only finding. For these patients, many physicians prescribe adequate rest, proper food at regular intervals, graduated exercises (especially for the patient with "visceroptotic habitus"), and a scientifically designed anatomical support. Numerous reports show that this treatment results in the gradual disappearance of the digestive symptoms with improvement in general health and weight gains for the thin patient. In time the support may be discarded.



*Camp supports for visceroptosis are fitted and adjusted with the patient in the partial Trendelenburg position. Pads are frequently used under the direction of the physician.*

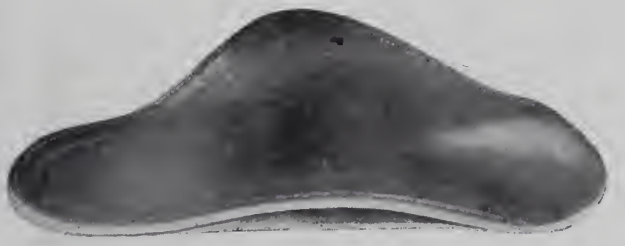
Camp Supports are also of assistance for postural defects that so frequently accompany the visceroptotic condition.

S. H. CAMP & COMPANY • Jackson, Mich. • *World's Largest Manufacturers of Scientific Supports*

*Offices in* NEW YORK • CHICAGO • WINDSOR, ONTARIO • LONDON, ENGLAND

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with mild longitudinal support.

Takes up little space in a dress shoe. A good support for women and growing girls.





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Made in duraluminum, monel metal, or stainless steel.

For advanced cases of metatarsal and longitudinal weakness.

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Plain or leather covered.

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*The Purple Heart—awarded to persons wounded in action against the enemy*

THE GUNS are silent once more. For the men with the guns, the war is over. But for the thousands of medical men in the service, the war still goes—their "war in white" in behalf of the wounded, the wearers of the Purple Heart. Doctors that they are, of medicine and morale, they well know how much a cigarette can mean to an invalid soldier. And servicemen that they are, as well, these doctors know what a big favorite Camels have been, and are, with men in all the services.

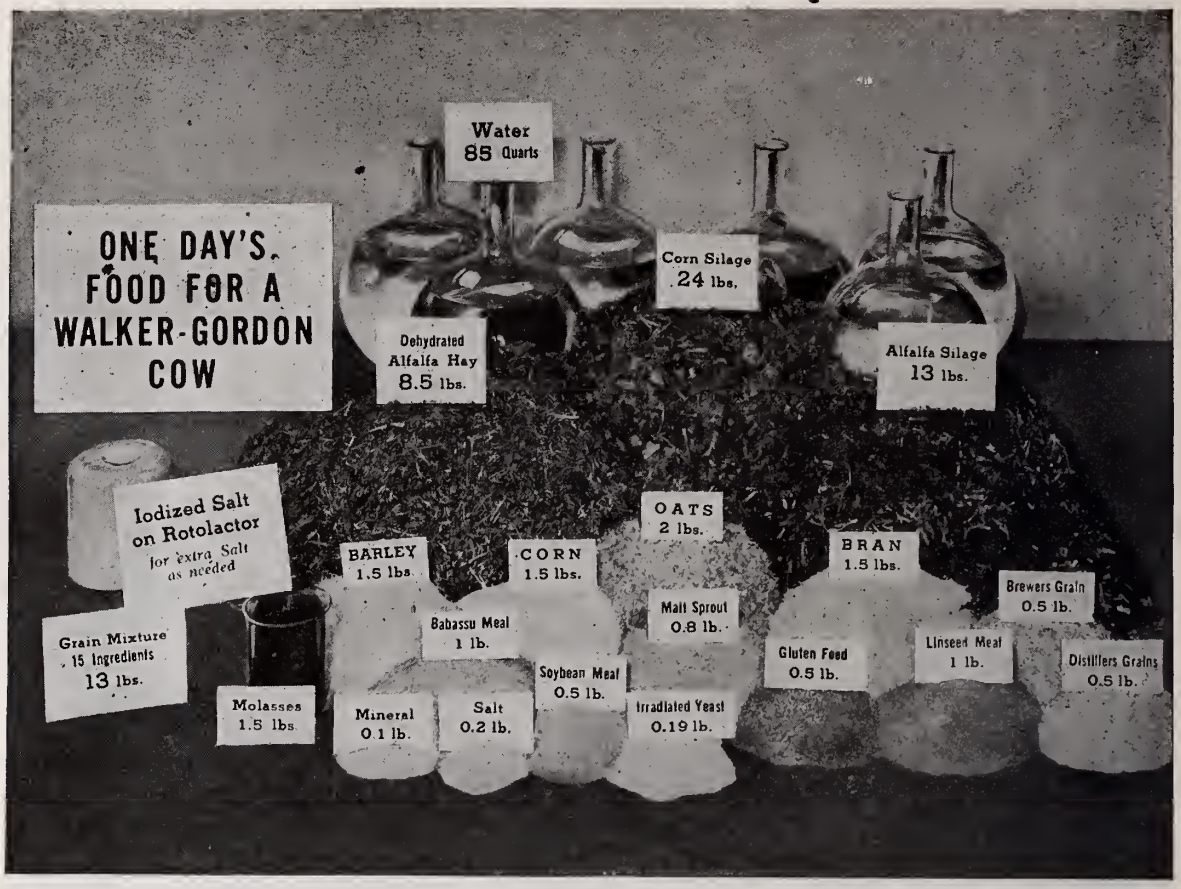





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# How many cows get a scientific ration like this?

THIS SCIENTIFIC daily ration was developed after years of study by the Walker-Gordon Laboratories.

It's remarkably rich in vitamins and health-giving minerals . . . And that's *one* big reason why Walker-Gordon cows produce a milk far superior to the type you get from cows that are fed in the ordinary, unscientific way.

**Take Vitamin A, for example. The alfalfa fed a Walker-Gordon cow is not ordinary alfalfa, but a special dehydrated kind containing 700% more Vitamin A. As a result, her milk contains more Vitamin A than many ordinary milks.**

And though the quantity of some other vitamins varies in ordinary milk (according to the season and what the cows find to eat), *the vitamin content remains uniformly high in Walker-Gordon Certified . . . regardless of the time of year!*

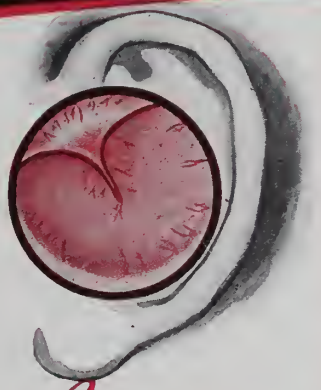
Then, too, Walker-Gordon Certified is delivered fresher than ordinary milk. This, plus the cows' wonderfully balanced diet, makes its Vitamin C content higher . . . and gives it a much finer, richer taste.

So it's easy to see why more and more physicians recommend Walker-Gordon Certified to their patients. They believe it's well worth a few pennies extra to get this marvelously pure milk with all its added nutritional values.

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***The World's Finest Milk***

# Medications of Choice FOR THE SPECIFIC INVOLVEMENT



## Auralgan

### in ACUTE OTITIS MEDIA

*Symptoms*

Pain, fever, edemo, leucocytosis, sense of fullness and impaired hearing.

*Treatment*

Relief of pain ond inflammotion—*Auralgan.*

*Action*

Decongestant, analgesic, bocteriostatic.



## Otosmosan

### in CHRONIC SUPPURATIVE OTITIS MEDIA

*Symptoms*

Persistent dischorge, often foul smelling, usually no toxemio, no poin, no fever.

*Treatment*

*Otosmosan.*

*Formula*

Sulfathiazole corbomide 20% in glycerol (Doho).

*Action*

Deodorizes the discharge, liquifies unheolthy gronulations, bacteriostotic, permits normal epitheliolization.

**Scientific data and reprints of clinical studies reporting upon the use of Otosmosan available on request.**

*Complimentary quantities for clinical trial*

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Providing relief from the more distressing symptoms of the menopause, with a minimum of inconvenience and expense to both the physician and the patient, this synthetic estrogen is an important part of the scheme of management of the climacteric patient.

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*THE new light became visible like a dazzling meteor in the evening of the nineteenth century. It surrounded the morning of our own century with the rosy light of hope and promise. Like a glittering sun it shines resplendent on the working day of the twentieth century, revealing new fairways and fresh horizons in nearly every land in the world of science.* . . . **In commemorating William Conrad Roentgen this year—the centennial of his birth, also the semi-centennial of his discovery of the x-ray —one is inspired anew by the above tribute spoken by Dr. Gosta Forssell, of Stockholm, Sweden, before the Fifth International Congress of Radiology, held in Chicago in 1937.**

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# *Not Merely*

## ISOLATED NUTRIENTS

Essential though they are, vitamins are nevertheless not the only nutrients which may be lacking in the diet of persons physically below par. Nutritional imbalance, not infrequently the cause of poor physical stamina, excessive irritability, and poor appetite, may be attributable to other dietary-induced deficiencies. In consequence, adjustment of the entire nutritional intake is indicated.

Virtually any diet can be enhanced to a point of adequacy through the addition of three glassfuls of Ovaltine daily. Made with milk as directed, this delicious food drink supplies liberal quantities of most essential nutrients, as indicated by the table below. Qualitatively Ovaltine is equally valuable; it provides biologically adequate protein, readily assimilated and utilized carbohydrate, well emulsified fat, B complex and other vitamins, as well as essential minerals. Ovaltine proves advantageous both as a mealtime beverage and a between-meal snack. Its low curd tension insures rapid gastric emptying, hence it does not interfere with the appetite for the next meal.

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# *Ovaltine*

Three daily servings of Ovaltine, each made of ½ oz. Ovaltine and 8 oz. of whole milk,* provide:

| | | | |
|---|---|---|---|
| PROTEIN | 31.2 Gm. | VITAMIN A | 2953 I.U. |
| CARBOHYDRATE | 62.43 Gm. | VITAMIN D | 480 I.U. |
| FAT | 29.34 Gm. | THIAMINE | 1.296 mg. |
| CALCIUM | 1.104 Gm. | RIBOFLAVIN | 1.278 mg. |
| PHOSPHORUS | .903 Gm. | NIACIN | 7.0 mg. |
| IRON | 11.94 mg. | COPPER | .5 mg. |

*Based on average reported values for milk.

*SPENCERS are also Individually Designed for . . .*

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*And for Patients following . . .*

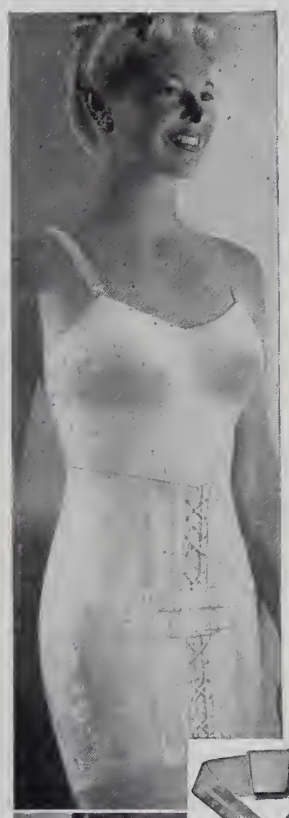
Hysterectomy
Nephropexy
Nephrectomy
Appendectomy
Cholecystectomy
Colostomy
Cesarean Section
Herniotomy
Spinal Surgery

Breast Conditions such as . . .

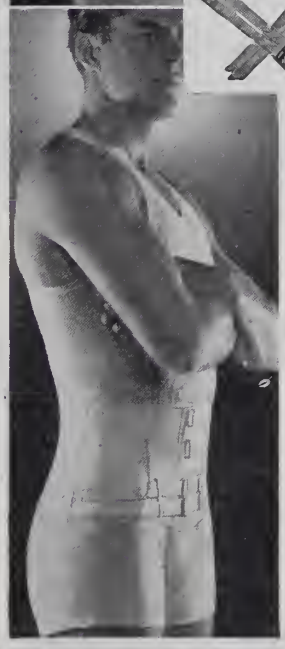
Ptosed Breasts
Mastitis — Prenatal
Nodules — Nursing
Prolapsed and Atrophic Breasts
Stasis in Breast Tissues

Following Mastectomy

# Sacroiliac or Lumbosacral Disturbances Relieved and Averted by Spencer Support







Instability in sacroiliac and lumbosacral areas is effectively checked by a Spencer Support designed to grip pelvis, and provide coordinated abdominal and back support. Thus posture is improved.

*Pelvic Band Aids in Inhibiting Movement*

A simple pelvic band is incorporated in the support. The band encircles the pelvic girdle *inside* the support and is instantly adjustable from *outside* the support to any degree of snugness required. When the condition subsides, the band may be removed and the remainder of the support worn as a safeguard against recurrence of acute symptoms.

Spencer Supports designed for a man and a woman are pictured *at left*. The small insert shows the band which encircles the pelvic girdle. At center-front of the closed supports can be seen the tapes and slides by which pelvic band may be adjusted without disturbing the support.

*Why Spencer Supports Are So Effective*

Each Spencer Support is individually designed, cut and made at our New Haven Plant *after* a description of the patient's body and posture has been recorded—and 15 or more measurements have been taken. This assures the doctor that each patient will receive the proper design to aid his treatment; that the support will improve body mechanics and will fit with the precision and comfort necessary. Yet a Spencer costs little or no more than an ordinary support.

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are made in gradations of 5 millimeters in sizes ranging from 50 to 95 millimeters inclusive . . . available through any recognized pharmacy.

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# ERYTHROL TETRANITRATE MERCK in Angina Pectoris

It is generally agreed that the acute attack of anginal pain is most readily relieved by the prompt removal of the provocative factor, and by the use of nitrites. For this purpose, the rapidly acting nitrous and nitric acid esters, amyl nitrite and nitroglycerin, are considered most useful.

For prophylactic purposes—to control anticipated paroxysms—the *delayed but prolonged action* of erythrol tetranitrate is more effective. Erythrol tetranitrate, because of its slower *and more prolonged action*, is also considered preferable for the purpose of preventing nocturnal attacks.

The vasodilatation produced by Erythrol Tetranitrate Merck begins 15 to 20 minutes after administration, and lasts from 3 to 4 hours.

***The properly timed administration of a vasodilator having a sustained effect may prevent the following episodes of angina pectoris:***

- **The man who finds it necessary to stop and rest when he walks to the train in the morning.**
- **The man who suffers "indigestion" and "gas" on exertion, or after a heavy meal.**
- **The man who has pain in his chest and arms, and weakness upon any anxiety, anger, or nervous strain.**







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Originated as a non-irritating, non-lathering replacement for soap in various skin disorders, Acidolate also successfully solved the problem of removing residual ointments, creams and oils from the hair, scalp and glabrous skin, because it:

1. Emulsifies ointments and other fatty materials almost immediately on addition of water. Low surface tension brings this concentrated yet bland detergent into intimate contact with the superfluous matter and permits deep penetration of skin crevices.
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# *Physicians know from clinical experience*

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*(Davies, Rose)*




**They conform now,**
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Each pill is equivalent to 1 U.S.P.XII Digitalis Unit. "One United States Pharmacopoeial Digitalis Unit represents the potency of 0.1 Gm. of the U.S.P. Digitalis Reference Standard."—U.S.P.XII.

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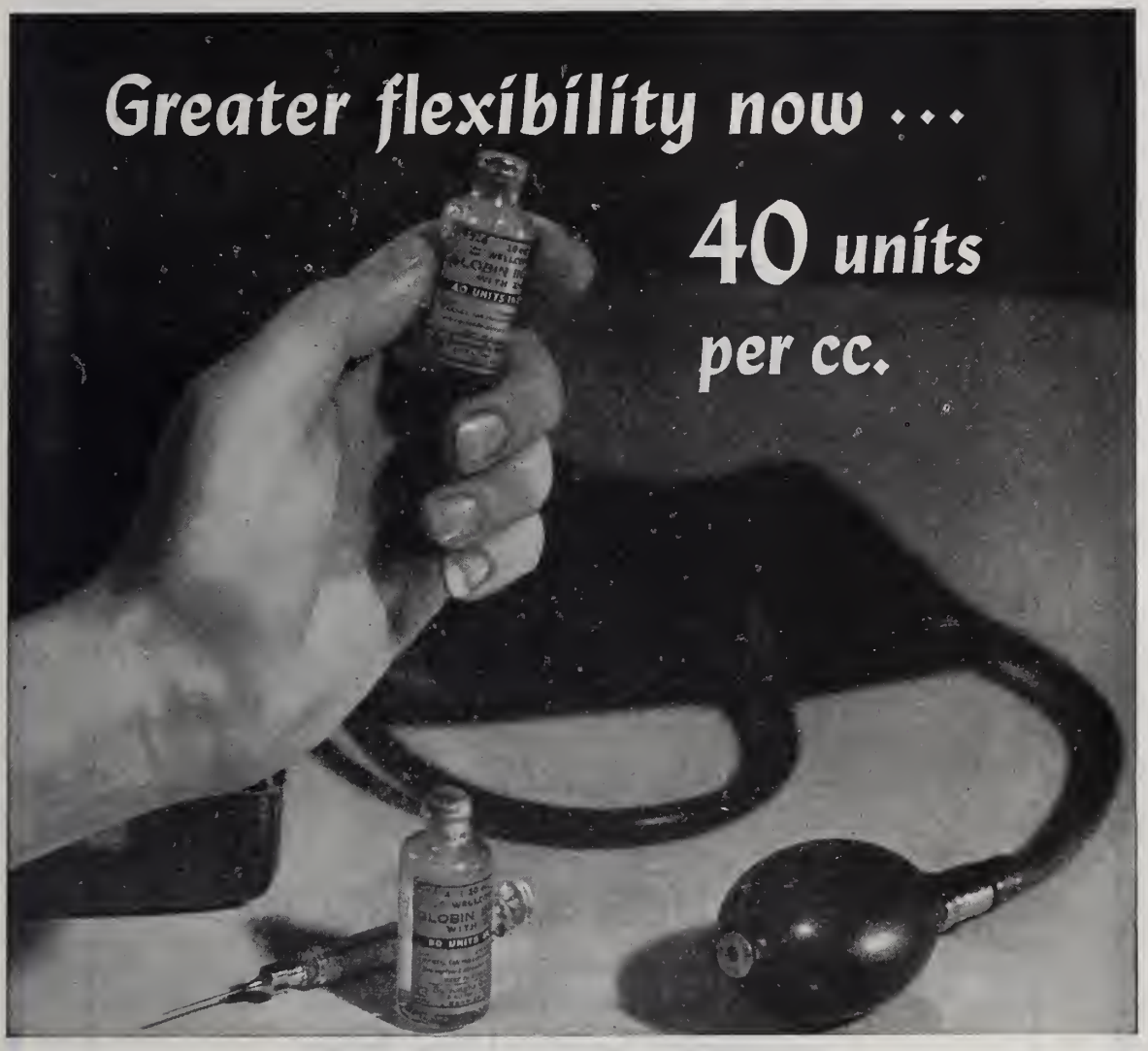

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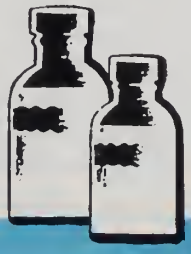

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Standardized by colorimetric and biological methods and supplied with the approval of the Research Institute of Endocrinology, McGill University.



**"Premarin" TABLETS**

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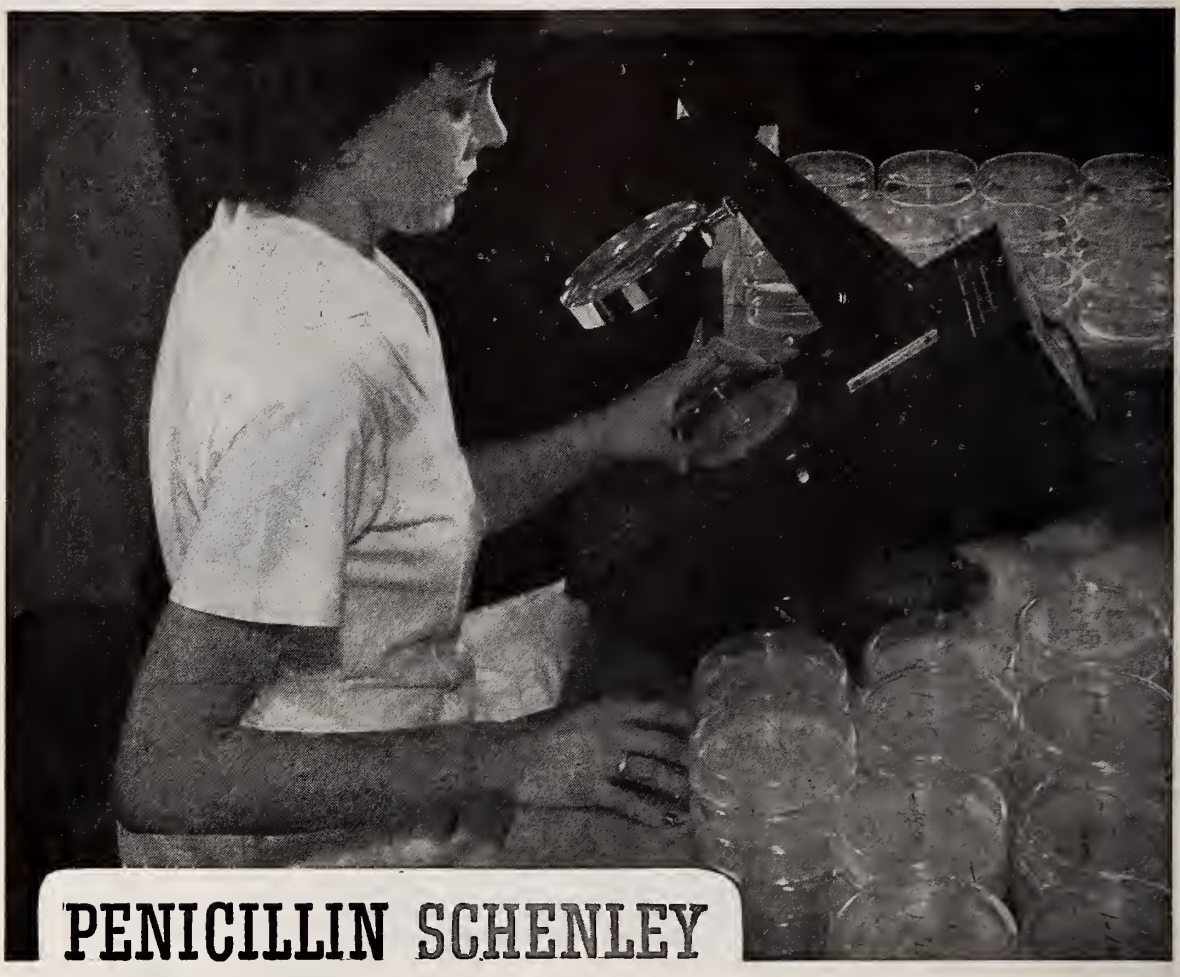
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FIRST YEAR OF LIFE






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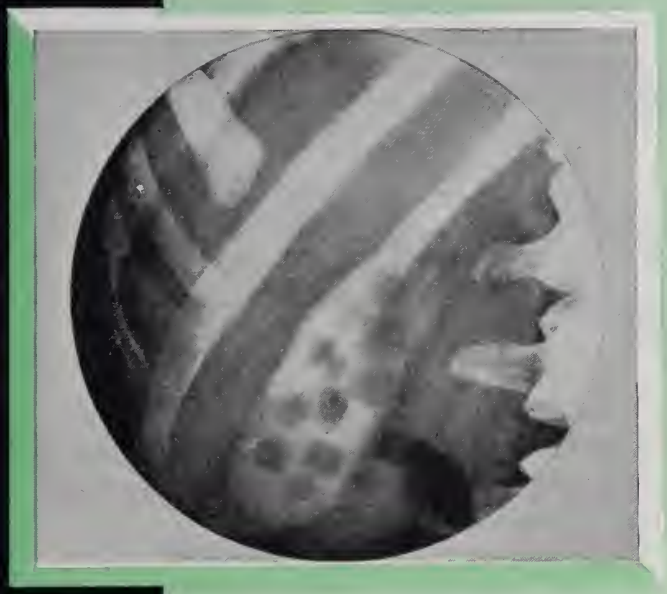
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1. Hefke, H. W.: Radiology 42:233, 1944.
2. Bryan, L., and Pedersen, N. S.: Radiology 42:224, 1944.

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**CARTOSE*** is prepared especially for use in modifying milk for feeding infants. It provides definite proportions of nonfermentable high dextrins, maltose and dextrose.

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## MIXED CARBOHYDRATES

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* *Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154*
*Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60*

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## Eye Physician (M.D.)---Guild Optician Way

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# THE VITAMINS A and D OF COD LIVER OIL STILL AVAILABLE — *with Marked Economy*

The preference of so many physicians for the *natural* A and D vitamins is not surprising in view of the widespread use of cod liver oil as *the* source of these essential nutrients.

## *White's* COD LIVER OIL CONCENTRATE

provides the *natural* vitamins A and D derived exclusively from cod liver oil and free from excess bulk and fatty oils.

Dosage forms suited to every type of patient afford maximal convenience of administration. *DROP DOSAGE* for infants and young children; *TABLETS* (which may be chewed) for growing children; *CAPSULES* for adult dosage as during pregnancy, lactation, convalescence and in old age.

ECONOMICAL—Prophylactic antirachitic dosage for infants costs less than one cent a day.

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# "another three ounces— just right, young man"

...A familiar statement by physicians prescribing Biolac for infants deprived of human milk.

The protein level of Biolac assures an adequate supply for growth and health, with small, soft curds. The adjusted milk fat facilitates digestion and assimilation with greater freedom from "fat upsets"; and the ample lactose content assures a soft natural stool formation. The adequate proportions of lactose, iron, and vitamins A, $B_1$, $B_2$ and D eliminate the need for time-consuming calculations of extra formula ingredients. Indeed, Biolac (supplemented with vitamin C) provides *completely* for infant nutritional requirements throughout the bottle period.




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**Cannon, P. J.: J. Am. Diet. Assn. 20:77 (1944)*

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

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The use of purer penicillin has markedly reduced such complications as phlebitis, pain at the site of injection, pyrexia, vascular and sympathetic disturbances, as well as muscular cramps.*




When you employ Bristol Penicillin in your practice you will find it:

1. Uniformly high in potency per milligram and
2. Markedly light in color.

Order Bristol Penicillin through your physician's or hospital supply house.

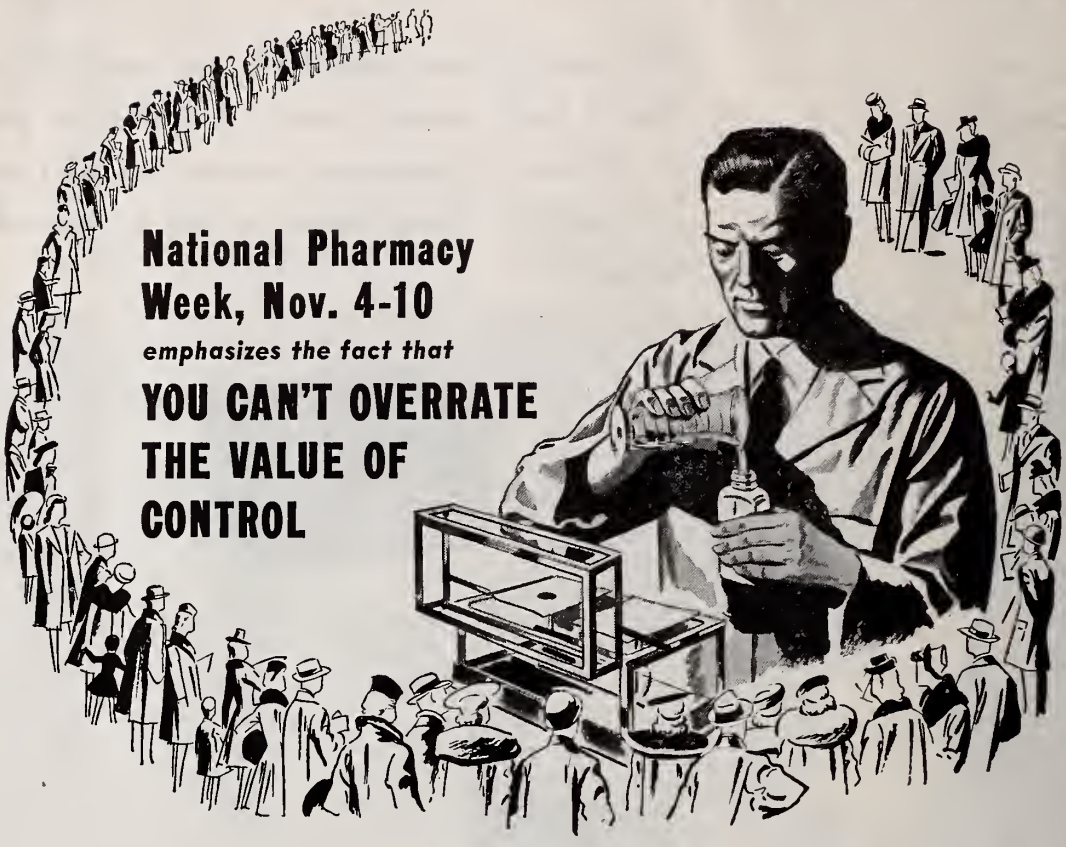
## BRISTOL PENICILLIN

*Keys, J.E.L.: Penicillin in Ophthalmology, J.A.M.A. 126: 610 (Nov. 4) 1944.

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• Translating physicians' orders into finished formulae is a responsibility highly valued and solemnly regarded by more than 10,000 skilled pharmacists in conveniently located Rexall Drug Stores throughout the land.

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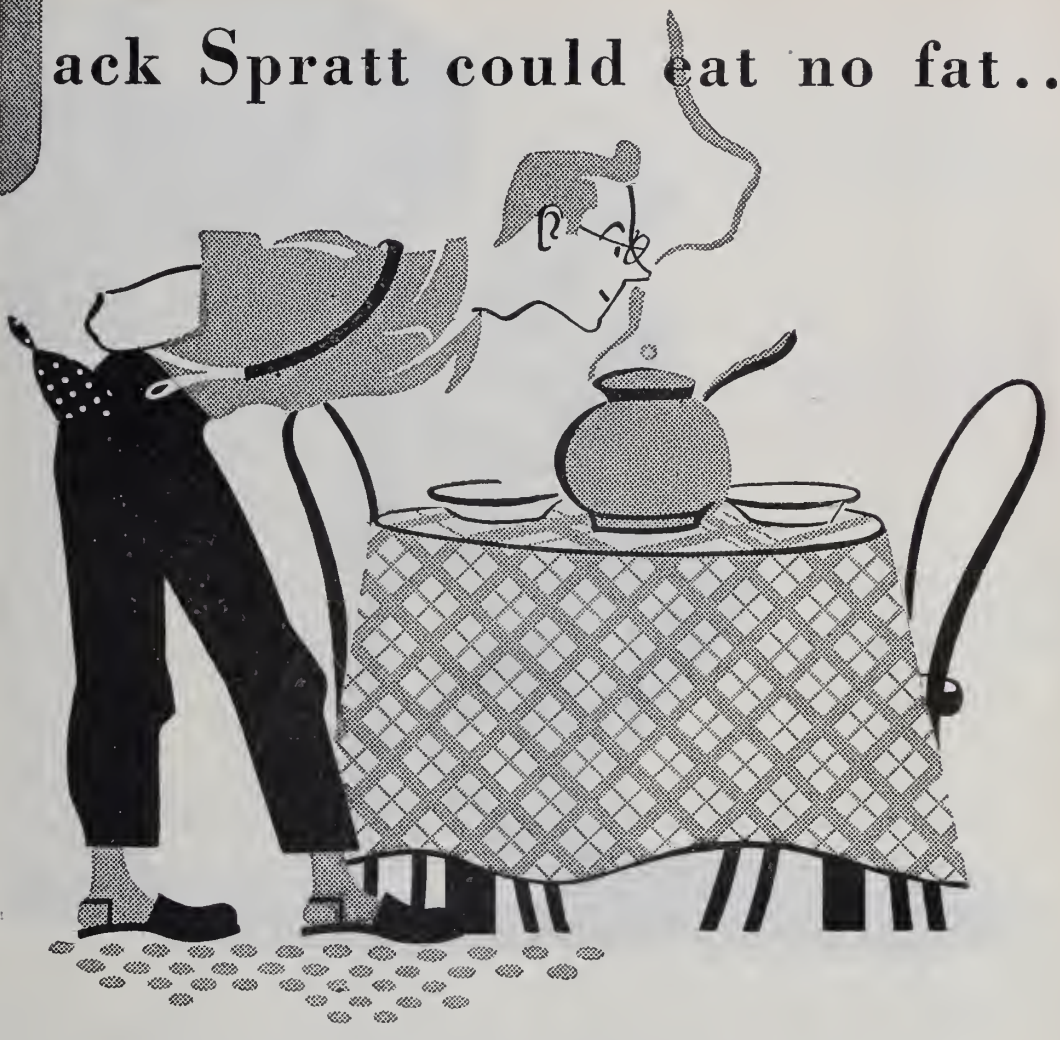
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# Jack Spratt could eat no fat...

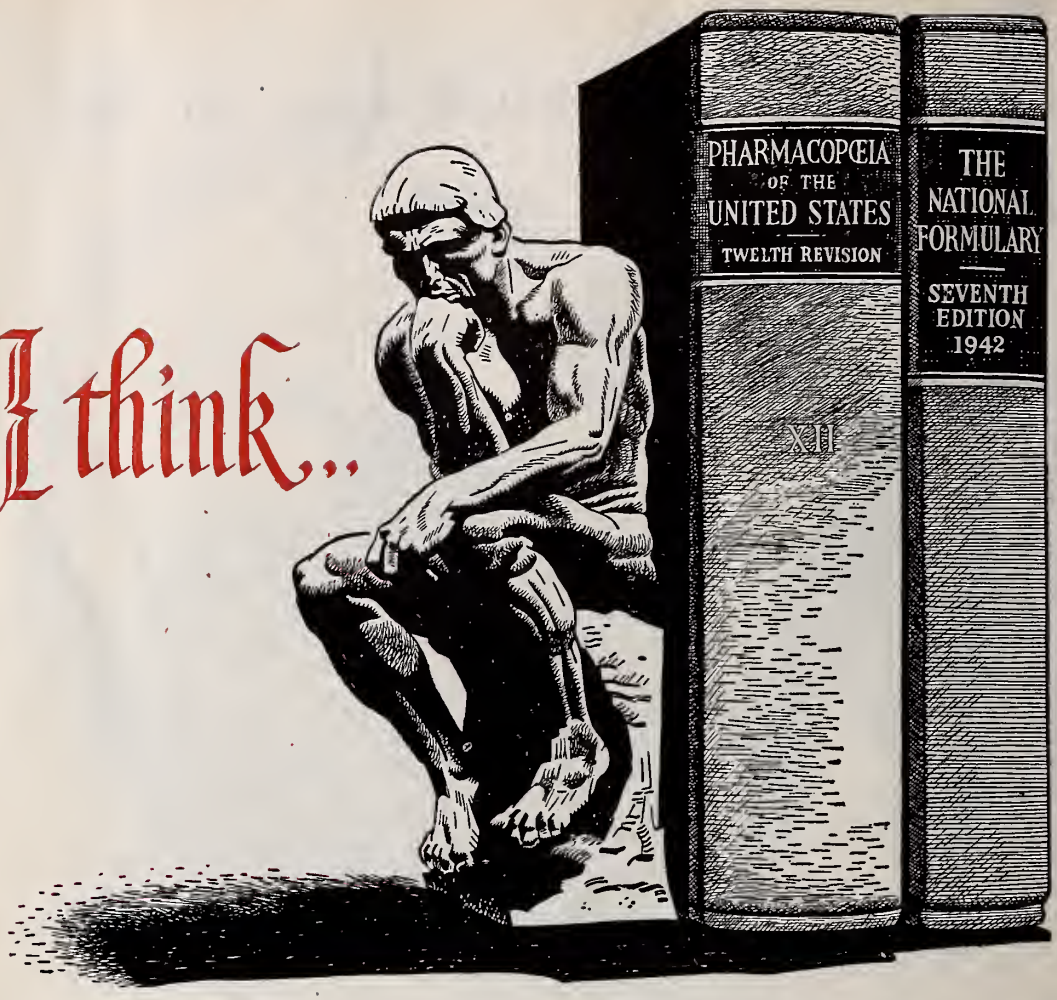


Finicky, fanciful, and foolish, the American palate selects its food neither too wisely nor too well—and therein lies the greatest reason for widespread vitamin deficiencies. When vitamin supplementation is indicated, it can readily be achieved with a potent, balanced, yet easy-to-take, low cost Upjohn vitamin preparation.

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THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

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Direction of the
Committee on Publication




Henry C. Barkhorn, M.D., Chairman

Henry A. Davidson, M.D., Editor
In Active Service A. U. S.

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# EDITORIALS

## THE SPECIALIST AND THE VOLUNTARY MEDICAL SERVICE PLAN MOVEMENT

The voluntary medical service plan movement as sponsored and operated by organized medicine as an alternative for compulsory sickness insurance, is based upon the tenet that physicians' fees should be adjusted to the ability of the individual to pay for medical services. This tenet is recognized by all physicians, general practitioners and specialists.

The subscription rate of each Plan is designed to produce an income to the Plan which will support fees consistent with those payable by persons with below-average income, and the contract of each Plan contains some provision to allow for payment by the subscribers of an additional amount to the physician for services rendered persons with above-average income.

Our services as specialists are necessary in maintaining high standards of medical care rendered through these Plans, yet it is not actuarily possible at this time for Plans operating on an insurance basis to pay a specialist a larger fee than that payable to a general practitioner for a specific service.

This effort to protect the future welfare of medicine as a private enterprise means as much, and perhaps more, to the specialist group than to the general practitioners. The development of and demand for specialists' services has constituted an important factor in the increase in the cost of medical care. Proposed national legislation would fix the fees for specialists' services, regardless of the income of the patient. My plea, therefore, is that members of the specialty groups give full support to the voluntary medical service plan movement, assured that as these Plans gain experience they will be better adjusted to our needs than will any government controlled program.

Henry C. Barkhorn, M.D.

## MEDICAL CARE OF THE INDIGENT AND LOW WAGE GROUP

In the Spring of 1945 the Committee on Medical Care of the Indigent and Low Wage Group distributed a questionnaire of five questions to each County Medical Society. The questionnaire was completed and returned by 15 County Societies.

The questions and a summary of the replies follow:

1. How are the indigent and low wage groups handled in your County?

All replies indicate that the care of the indigent is satisfactory as administered through local welfare agencies excepting in a few instances where the local communities do not give sufficient recognition to their obligations to the indigent.

Most of the replies did not specifically mention the low wage group as distinct from the indigent, except to note that this group at present constituted a very small percentage of the population.

2. How are the indigent chronic ill cared for?

Those cared for in their homes, offices of physicians and clinics are receiving adequate care. Facilities are ordinarily adequate for the care of the tuberculous, the mentally ill and those with contagious diseases through State or County facilities.

There is a need in all counties for additional hospital facilities to care for chronic illnesses occurring among the indigent.

3. How are the medically indigent cared for?

This question was apparently not clear, as stated in one returned questionnaire. The majority of replies stated that this group was cared for under the same arrangements as provided for the indigent. This may be true in certain communities but is not widespread. The average reply indicates a lack of differentiation, in the minds of those answering the question, between the indigent and medically indigent. The indigent, officially, are those whose names appear on the welfare rolls of the community. The medically indigent are those whose income will provide for the necessities of life but will not provide for the payment of any type of adequate medical care—the so-called single phase relief person which most communities do not recognize. They are recognized by the City of Newark, based upon the opinion of the investigators of the City Board of Health. In Newark this group is at present larger than the indigent group. They are admitted to city clinics for out-patient care and cared for when sick at home at city expense through the City of Newark Medical Plan, administered by Medical Service Administration. They represent an economic group which must be recognized at a local level and cared for at public expense if the medical care distribution problem is to be satisfactorily solved.

4. Is adequate medical care available for everybody?

The majority of replies consisted of one word, "Yes". Others qualified their remarks by calling attention—to the necessity of education of the public as to the facilities available and how services may be procured, to the necessity of our community governments recognizing their obligations under existing laws governing care of the poor, and the need for additional facilities for the care of the chronic illnesses among the indigent and aged.

5. What suggestions have you to offer for better medical care for the indigent and low wage group?

Three counties answered this question with the one word "None". Others called attention to the need of education of the people and community governments as to the value of proper programs for the care of the indigent and the expansion of

voluntary sickness insurance plans. One county criticized our present voluntary plans as being inadequate. Practically all advised expansion of hospital facilities to meet the need of the chronically ill.

The Committee submits the following comments on the problem:

The problem could be handled more economically and effectively on a county basis, rather than on a municipal basis, with all municipalities within each county following a common pattern.

The care of the medically indigent, as determined within the county, as well as the care of the indigent, should be made available through State subsidy.

Facilities for the care of the chronically ill must be on a county basis, yet the majority of County Freeholders do not recognize this problem as a county responsibility, but rather as a municipal responsibility. With few exceptions our municipalites do not have sufficient population or income to deal with this part of the problem.

---

## THE PRINCIPLES OF MEDICAL ETHICS AND RETURNING MEDICAL OFFICERS

The Principles of Medical Ethics of the American Medical Association contains two paragraphs of particular significance at this time. An intelligent interpretation of these paragraphs should guide every physician who remained in private practice during the war period.

### A Colleague's Patient

Section 7. When a physician is requested by a colleague to care for a patient during his temporary absence, or when, because of an emergency, he is asked to see a patient of a colleague, the physician should treat the patient in the same manner and with the same delicacy as he would have one of his own patients cared for under similar circumstances. The patient should be returned to the care of the attending physician as soon as possible.

### Relinquishing Patient to Regular Attendant

Section 8. When a physician is called to the patient of another physician during the enforced absence of that physician, the patient should be relinquished on the return of the latter.

---

## A MEDICAL CARE CREDO OF THE MEDICAL PROFESSION
## TEN BELIEFS OF ORGANIZED MEDICINE AS TO MEDICAL CARE

### MEDICAL RESPONSIBILITIES

**The Medical Care Responsibility of Organized Medicine**

1. WE BELIEVE, that, in the same manner that a physician is doctor of his *individual* patients, and feels a definite responsibility for their *good health* and *medical care;* every *County Medical Society,* collectively and figuratively speaking, is the doctor of the people of its *County;* every *State Medical Society* is the doctor of the people of the *State;* and the A. M. A. is the doctor of the people of the *Nation,*—and all feel a definite responsibility for the health and the *quality, quantity, availability,* and *distribution* of *medical care* for the American people.

### SOLUTION OF THE MEDICAL CARE PROBLEM

**The Solution of Good Medical Care for the American People**

2. WE BELIEVE, that, in order to see that *good quality* medical care is provided for the American people, as well as a *continued improvement* in the *quantity, availability,* and *distribution* thereof, it is essential that a real *teamwork* Medical Care Conference in the *public interest,* organized on a *complete basis* of *equality, good faith,* and *goodwill,* is promptly created by the medical profession or the government (or preferably by joint action), instead of the present murky atmosphere of mutual suspicion and distrust which now exists.

### THE PARTICIPATION OF ORGANIZED MEDICINE

**The Quality of Medical Care in Governmental Public Medical Care Programs**

3. WE BELIEVE, that the *quality* of medical care in any governmentally administered health service program involving the public and the medical profession is *now* and *will be* in *direct* proportion to the *voluntary* participation of the medical profession in both the *formulation* and *administration* of such programs.

### THE PUBLIC AND MEDICAL CARE

**The American People and Good Medical Care**

4. WE BELIEVE, that the *American people want good quality* medical care. They also want it made *more available* to everyone.

### THE MEDICAL PROFESSION AND MEDICAL CARE

**The Medical Profession and Good Medical Care**

5. WE BELIEVE, that the medical profession is insistent on rendering *good quality medical* care. They also are working to make it *more available* to *everyone.*

### THE SOCIAL ENGINEERS AND MEDICAL CARE

**Social Engineers and Medical Care**

**Quantity Versus Quality**

6. WE BELIEVE, that the non-medical and medical *social engineers* who *proposed* governmental medical care and (1) the social agencies, (2) labor organizations, and (3) governmental agencies who have *espoused* and *promoted governmental medical care* to be paid for by the *compulsory taxation* of *every citizen* of the United States, are *chiefly* and *primarily* concerned with the *quantity, availability,* and *distribution* of medical care. They are also secondarily interested in the *quality* of medical care.

### FACTORS IN MEDICAL CARE QUALITY

**Determining Factors in Quality of Medical Care**

7. WE BELIEVE, that, except in the patriotic rendering of medical services in time of war and a few other scattered instances, there are *certain definite factors* which *usually* produce *definite deterioration* in the *quality* of *medical care* under *government auspices.*

These *definite* and *inescapable* factors are

(1) The great difficulty of securing *able* (Class A) physician *personnel*

(2) *Too many patients per hour*

(3) *Unsatisfactory physician-patient relationship*—(Lack of that *time consuming* and *all important psychological* and *psychiatric factor* which allows physicians to relieve *mental tensions* and *anxiety* in *their* patients)

(4) *Low rates* of *compensation*

(5) Multiplicity of governmental *rules, regulations,* and *reports* (so-called governmental red tape), which hamper the rendering of *good medical service.*

We believe these are the five *factors* that caused the recent difficulties as to the *quality* of *medical care* rendered veterans by the Veterans Administration facilities as testified to by government officials. We believe that these are the five *factors* which *do* and *will* make any program of governmental medical care result in *mediocre quality* unless the *organized medical profession* is immediately given a *permanent* and *equal* share in the *formulation, revision,* and *administration* of all governmental medical programs, which affect the general public. We believe that such an *equality* of coöperative effort on behalf of the best possible *quality, quantity, availability* and *distribution* of medical care for our American people by medical and governmental agencies, is in correct and full accord with the principles of American Democracy and should be instituted forthwith.

### THE WAGNER-MURRAY-DINGELL AND PEPPER BILLS AND THEIR EFFECT—NON-PARTICIPATION OF MOST GOOD PHYSICIANS

**Mediocre Quality of Medical Care under Wagner-Murray-Dingell and Pepper Bills Not Acceptable to Most Good Physicians**

8. WE BELIEVE, that, because the medical profession (organized medicine) has *not* officially participated in the *formulation* of the Wagner-Murray-Dingell and the Pepper Bills, and, because these bills give the medical profession no share in the *administration* thereof, the *majority* of most able physicians will *not participate* in these proposed programs of governmental medical care because the average *quality* of medical care would be *mediocre* or *low grade.*

### THE WAGNER-MURRAY-DINGELL AND PEPPER BILLS' UNHAPPY EFFECT ON PHYSICIANS' TYPES OF PRACTICE—THE WISE CHOICE OF THE PUBLIC

**Wagner-Murray-Dingell and Pepper Bills Would Create Unhappy Result of Two Kinds of Doctors**

9. WE BELIEVE, that the passage of these or similar bills, by the efforts of social work or labor groups in this country, which do not provide for the *participation* of the organized medical profession in the *formulation* and *administration* thereof, would *inevitably* and *unfortunately* for the public result in the creation of *two* kinds of physicians in this country—*private doctors* and *government doctors.* We believe the great majority of able physi-

**Preference of Public for Individual Personal Private Medical Service**

cians will stick to *private* medical care because they have in the *past,* and will in the *future, insist* on *conditions* which permit the rendering of *good quality medical service* to the public. In this connection, we believe that the *American public* today largely knows the difference between *good quality medical service* and *mediocre quality* medical care as evidenced by the marked wartime increased demand for *individual private* medical service and *greatly decreased attendance* at most types of *clinics.*

### THE MEDICAL PROFESSION'S PRESCRIPTION FOR IMPROVEMENT IN MEDICAL CARE

**The Medical Profession's Prescription for Remedial Action as to Improvement**

10. WE BELIEVE, that the best possible *quality, quantity, availability* and *distribution* of medical care for our American people can only be secured by the creation of a *permanent, working medical care conference* composed of (1) the *medical* and *allied health professions* concerned with medical services and (2) *governmental agencies* concerned with medical services.

### JOINT PLANNING FOR MEDICAL CARE

**In the Quality, Quantity, Availability and Distribution of Medical Care A Joint Democratic Working Conference in the Public Interest**

WE BELIEVE, that such a *joint coöperative conference* effort on the part of *medical* and *governmental* agencies could improve the *quality, quantity, availability,* and *distribution* of medical care for all of the American people by jointly planning care for (1) the *medical indigent* and *low-wage* groups—by the supplemental aid of general tax funds; (2) by caring for *those* of *moderate income* —by *voluntary health insurances* covering *hospital, medical, surgical, obstetrical* and *all other medical care expenses* and (3) by caring for those of *ample income*—as at *present.*

### A PERMANENT DEMOCRATIC MEDICAL CARE CONFERENCE OF MEDICAL AND GOVERNMENTAL AGENCIES

WE BELIEVE AND RECOMMEND, that such *permanent working conference* on *medical care* should be forthwith immediately created either by (1) the A. M. A., (2) the Congress of the United States, or (3) the President of the United States (preferably by *joint action* of these three), to be composed of an *equal* number of *official* representatives of (1) the *A. M. A.* and (2) the *governmental agencies* concerned with *health services;* and that the members of such conference be given *equal powers* of *action* to the end that the American people may be provided in our time with the *best possible quality, quantity, availability,* and *distribution* of medical care by *concerted American democratic action* with resultant *peaceful* solution of the medical care problems which concern us all.

Presented for adoption to the Public Health and Welfare Committees of The Medical Society of New Jersey, October 7, 1945, by Stanley Nichols, M.D., Chairman of the Public Health Committee.

# ORIGINAL ARTICLES

## ACUTE COR PULMONALE

Harry Halprin, Comdr. (M.C.), U.S.N.R.
and
Murry W. Shulman, Lt. Cdr. (M.C.), U.S.N.R.
U. S. Naval Base Hospital No. 3

This paper is presented as an example of electrocardiographic findings in a case of acute cor pulmonale taken within 5-7 minutes after the onset of symptoms. It may perhaps be because of our limited library facilities at this present locality, but as far as we can tell, there are no recorded cases where tracings were taken in less than two hours after the accident occurred. The E. C. G. record obtained in this particular case differs to a great extent from those presented as typical of the condition.

O. W. H., SC3c, U.S.N.R.; age 31.
Admitted 9-8-44
Diagnosis: Appendicitis, acute.
Expired: 1500—9-13-44.
History: C. C. Pain in epigastrium 72 hours, at present localized to right lower quarter.
T—99.6.
WBC—7650—58% Poly's.

Patient was observed without medication until the following morning when pain, tenderness, rigidity in right lower quadrant became more marked, accompanied by rectal tenderness.

*September 9*—Appendectomy was done through a McBurney incision under Spinal Procaine, 125 mgs. Operation uneventful. Convalescence was satisfactory. Maximum temperature was 100.2 on the first post-operative day and showed a gradual decline thereafter.

Pathology of Appendix: Subacute Catarrhal Appendicitis.

On 9-13-44, the fourth post-operative day, at 1450, patient sat up in bed complaining of substernal pain.

He immediately became:
1. Dyspneic with rapid respiration.
2. Cyanotic.
3. Pulse feeble.
4. Veins in neck moderately distended.
5. Blood pressure low, 80/60. Pupils were dilated. Skin cold and clammy. Heart sounds were muffled, regular at first and soon became irregular.

*Lungs*—Were fairly clear with moist râles in both bases but there was a marked respiratory difficulty with respirations rapid and gasping. Expired in 10 minutes from time of onset of symptoms.

*Differential Diagnosis:*
1. Pulmonary Embolus.
2. Coronary Occlusion.

Subject: Report of Autopsy in the case of O. W. H., SC3c, V-6, U.S.N.R.

Body of Negro male, six feet two inches in height, weighing about one hundred and fifty (150) pounds. Body warm, rigor absent. Eyes dark brown, with pupils dilated and equal. No petechiae present. Tongue is behind teeth. Small amount of clear, frothy mucus in mouth. Scant, black moustache. Large abdominal dressing covering a right, surgical McBurney incision, three inches long, closed with six metal clips. Many old scars on both knees and over the anterior surfaces of both tibiae.

*Head:* Not opened.

### Thoracic Cavity

*Sternum is free.* Anterior mediastinum is free. Thymus atrophic.

*Pericardium free.* Contains about one ounce of clear, straw-colored fluid.

*Heart:* Normal position. Apex between the fourth and fifth ribs, in the anterior axillary line. The superior vena cava is distended for about four centimeters above its termination into the right auricle. Stuffed into the upper portion of the cavity of the right auricle, and apparently caught in the opening of the superior vena cava into the right auricle, is an embolus. It is in two portions, each four centimeters long and about two centimeters in diameter. They are partially broken, reddish in color, and with layered lines of platelets distinctly visible. Their ends appear as if they had been broken off. The superior vena cava has been so distended that it is just beneath the sternum. The right auricle is distended with a considerable amount of fluid blood and some dark-red, stringy clots, which appear to be different from the usual post-mortem clots. The right ventricle is also greatly distended with fluid blood, and it also contains a few dark-red clots which were caught beneath the valve leaflets. The endocardium and valves are otherwise free. The left ventricle is in firm rigor. The orifices of the coronary arteries are free, and the coronaries are normal thoughout their distribution. The muscle is dark-red, with distinct bundles, and is two centimeters thick. The heart weighs three hundred and fifty-five (355) grams.

The *aorta* is free and elastic, with a few yellow flecks of atheroma.

*Right Pleural Cavity:* Free. No fluid; no adhesions.

*Right Lung:* Pleural surfaces are free. Hilar nodes are anthracotic. Stuffed into the right pulmonary artery is the major portion of the embolus. The platelet portion is mostly caught in the heart, but the red portion is practically all in this portion of the pulmonary artery. The pulmonary veins are normal. There is an embolus in the superior divisions of the right pulmonary artery down to the medium-sized divisions. The lung, on section, is light red. There is a small amount of frothy, blood-stained edema throughout. It weighs two hundred and forty (240) grams.

*Left Pleural Cavity:* Dry. No adhesions present.

*Left Lung:* Contains a few fragments of embolus, scattered in the larger branches, otherwise is the same as the right. Weighs one hundred and sixty (160) grams.

### Abdominal Cavity

Topography normal. There are about one hundred fifty (150) cubic centimeters of bloody fluid in the abdominal cavity. The omentum is lightly adherent to the recent incision, which is well closed. There is a light omental adhesion to the descending colon in its mid-portion.

*Stomach:* Contains about six ounces of digested food material. Mucosa free.

*Duodenum, jejunum,* and *ileum* are free.

The appendix is absent. The colon is free. The site of the appendectomy is free and there is no suppuration present. There is a fatty tag of mesentery sutured over the inversion site, which is not necrotic.

*Pancreas:* Normal size and conformation; well-packed parenchyma.

*Spleen:* Weighs eighty-five (85) grams, and measures ten by five and five-tenths by two and five-tenths (10 x 5.5 x 2.5) centimeters. Capsule free and clear. One section is dark-red, with pronounced lymphoid markings.

*Left Adrenal:* Normal size and position. Well-packed parenchyma.

*Left Kidney:* Measures ten by five by two and five-tenths (10 x 5 x 2.5) centimeters, and weighs one hundred forty-five (145) grams; otherwise is the same as the left.

*Bladder:* Contains about eight ounces of clear, amber urine. Prostrate free.

### Embolus

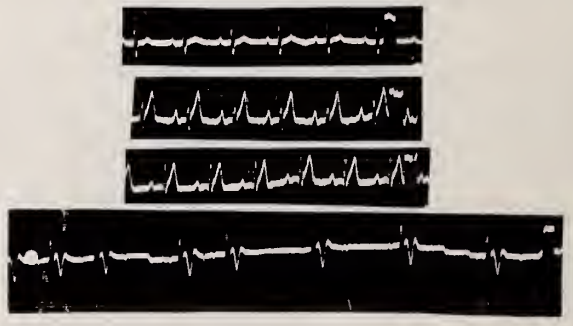
Total length measures fifty-five (55) centimeters and is divided into ten large pieces. It tapers from two centimeters in diameter to about five millimeters, and the largest end consists of a platelet thrombus; the rest, a red thrombus.

Both iliac and femoral veins were dissected free. No residual thrombus or internal roughening was observed. The long saphenous vein showed no changes.

## SPECIAL EXAMINATION AND TREATMENT REQUEST

Date: 9-13-44. U. S. Naval Hospital. Base No. 3
Name—O. W. H., U.S.N.R. Rate SC 3/c. Ward B-S
Diagnosis—Appendicitis, Acute, No. 304 Referred to E. C. G.
Exact examination desired, E. C. G.
A. 31
W.
H.

Comdr. Harry Halprin, (M.C.) U.S.N.R.



### REPORT

Rate 73

Rhythm—normal sinus in coplex 1 2 3. In lead IV P wave persists but T-P interval becomes longer and rhythm is irregular.

P-R—.24 QRS.—.08-.10 Deep S1—2

Absence of definite ST 1-3 elevation or depression; all T waves upright except definite T4 inversion.

T4 early and complete inversion.

Interpretation:

E. C. G. is not typical of pulmonary embolism because of absence Q3 and absence of T3 inversion and ST 1 depression and ST 3 elevation. It is more typical of posterior infarction, yet autopsy shows Pulmonary Embolus.

Acute Cor Pulmonale.

### ANATOMICAL FINDINGS

1. Embolus into pulmonary artery, predominately right; origin not determined.
2. Moderate pulmonary edema.
3. Post-operative appendectomy.

### MICROSCOPIC EXAMINATION

*Liver:* Normal histological structure.

*Kidney:* Moderate droplet degeneration of tubules. Congestion of glandular capillaries.

*Heart:* Normal structure.

*Spleen:* Normal structure.

*Embolus:* Sections through various portions show that the "head" is composed of typical strands and branching columns of blue-staining amorphous material, surrounded by layers of leucocytes, and with interlacing strands of fibrin, enmeshing erythrocytes.

### ANATOMICAL DIAGNOSIS

1. Cloudy swelling and hyperemia of kidney.
2. Normal heart structure.
3. Pulmonary embolism; origin probably from a femoral vein.

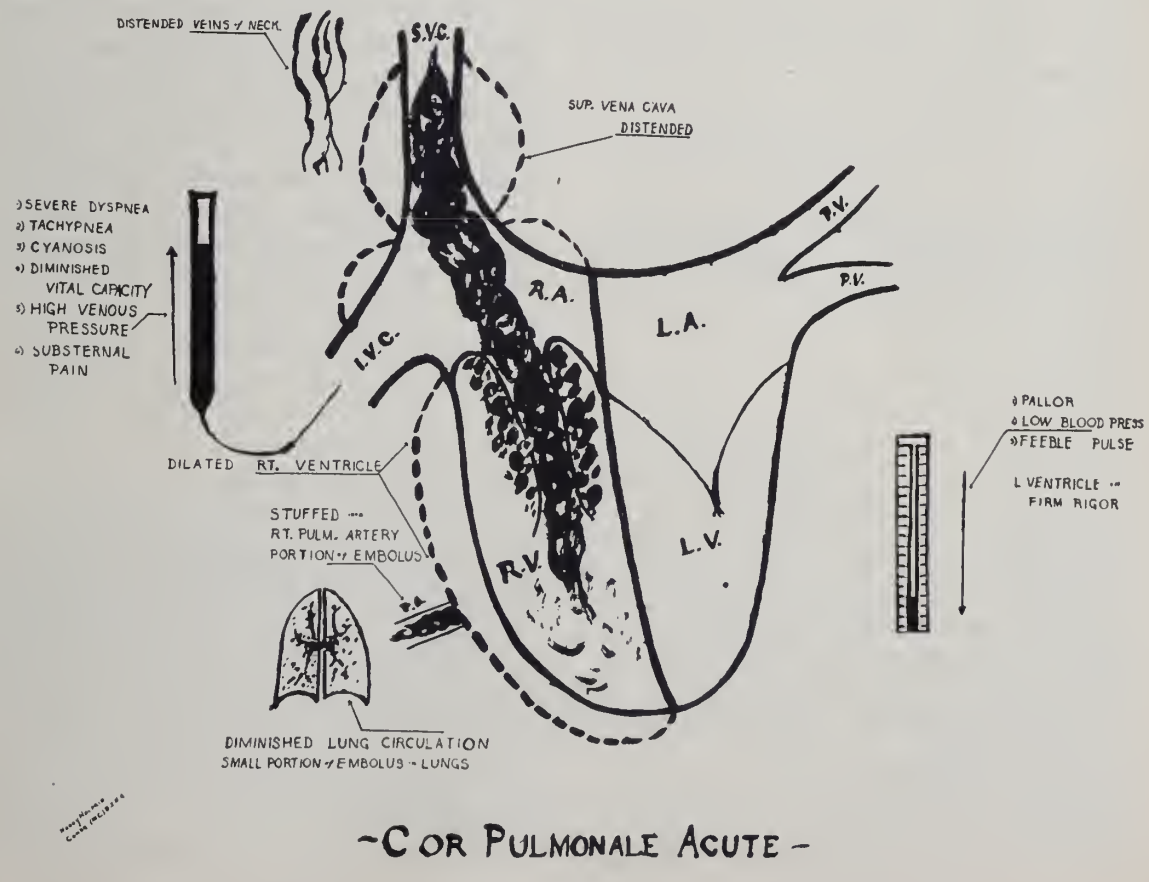
### CAUSE OF DEATH

Principal: Embolism, Pulmonary, No. 223.
Contributory: Appendicitis, Acute, No. 304.

### DISCUSSION

Sudden obstruction of the pulmonary circulation produces a clinical picture characterized by:

1. Peripheral circulatory collapse caused by decrease in cardiac output resulting in signs of shock, characterized by:
   a. Ashen pallor.
   b. Feeble pulse.
   c. Profuse perspiration.
   d. Low blood pressure.
2. Anoxemia due to lack of oxygenation of the arterial blood is revealed clinically by:
   a. Severe dyspnea.
   b. Tachypnea.
   c. Cyanosis.
   d. Substernal oppression.
   e. Diminished vital capacity.
3. Acute dilatation and failure of the right ventricle (acute cor pulmonale) resulting from the marked increase in right intraventricular pressure.



a. Dilatation of the right ventricle and base of the pulmonary artery.

4. Other signs of acute cor pulmonale.

a. Accentuation of P2.

b. Thrill or murmur over the pulmonic area, due to stenosis of pulmonary artery.

c. Gallop rhythm.

d. Enlargement of neck veins.

e. Increased venous pressure secondary to auricular dilatation.

5. Coronary insufficiency due to diminished coronary blood flow (a product of the three preceding factors).

The cardiac ischemia which follows adds to the degree of dyspnea and substernal oppression and further lowers the cardiac output.

The syndrome of dyspnea, tachypnea, cyanosis, substernal oppression and shock is clinically often indistinguishable from acute coronary occlusion, and the electrocardiogram becomes a valuable aid. Below is a description of the findings described as typical of the condition under discussion, acute infarction of the posterior basal portion of the left ventricle, and a résumé of the comparative features of the case in point.

*E. C. G. of Acute Pulmonary Embolism*

S1—almost constantly present and usually prominent.
ST1—little tendency to depression.
ST2—takeoff usually below the isoelectric level.
T2—diphasic isoelectric or upright; rarely inverted.
RT3—occasionally slightly elevated.
Q3—frequently fairly prominent; Q3 pattern not present.
RT4—rarely elevated.
T4—usually upright; may be flat or diphasic.

*Q3 T3 type E. C. G. charact. of Acute Infarction of the Post Basal Portion of Left Ventricle.*

S1—absent, if present not exaggerated.
ST1—usually definitely depressed in early stage of infarction.
RT2—usually elevated, rarely isoelectric and never depressed.
T2—usually inverted, especially subacute infarction.
RT3—much elevated as a rule in the acute stage of infarction.
Q3—frequently markedly prominent Q3 pattern commonly present.
Q4—usually within normal limits.
RT4—frequently elevated in 1st 3 days after acute infarction.
T4—usually inverted, upright in rare instances.

*E. C. G. Findings in case presented:*

S1—present and prominent.
ST1—not depressed.
ST2—takeoff slightly above the isoelectric level.
T2—definitely upright.
RT3—slight elevation.
Q3—absent.
RT4—not elevated.
T4—definite inversion.

In lead 4 there is evidence of a wandering pacemaker.

It becomes increasingly evident that characteristic E. C. G. changes are not always observed after every instance of pulmonary embolism for which the clinical evidence seems conclusive.

*For example*—In cases of pulmonary infarction occurring in the course of congestive heart failure it may be assumed that in certain proportion of cases, the infarction was the result of an embolus arising from an endocardial thrombus. The embolus in these cases is small and occludes a relatively small branch of the pulmonary artery. However, the gravity of pulmonary embolism cannot in every instance be related entirely to the size of the vessel occluded. I have been impressed by the fact that those patients who exhibited the greatest circulatory embarrassment with features of shock following pulmonary embolism were the ones most likely to yield characteristic E. C. G. findings. No exact knowledge is available as to how soon these changes may be observed after pulmonary embolism; we have seen them as early as nine hours, and possibly as early as two hours afterward.

It would appear that the E. C. G. pattern following pulmonary embolism is a classic example of changes due to unilateral ventricular strain. Pathologic evidence in fatal cases reveals extreme dilatation of the right ventricle. The explanation has been offered that the E. C. G. changes are an expression of the insufficiency of the coronary arteries. According to one explanation, it is assumed that the coronary arteries are thrown into spasm by a reflex mechanism.

Pathologic examination of hearts of patients

who have died of pulmonary embolism frequently discloses no evidence of significant degrees of coronary sclerosis. More reasonable is the assumption that the coronary circulation is impaired as a result of the extreme fall in blood pressure, and the tachycardia observed in these cases. This limits the capacity of the right ventricle to cope with an increased pressure load. However, it is probably equivalent to saying that there has been a failure of metabolic exchanges in the muscle of the right ventricle. This appears to be the most logical basis for the E. C. G. changes observed.

It is interesting to note how much our findings differ from the classical electrocardiogram of pulmonary embolus. The explanation may lie in the fact that we have been missing the very early phase of the accident. The changes exhibited in the first few minutes are those due primarily to anoxia of the entire myocardium instead of the typical right heart failure. In other words, the electrocardiographic findings described as typical of the condition are those found several hours after the accident and these tracings are true evidence of right heart failure. However, from the case presented we must assume that there is another and earlier phase of the syndrome which may have been overlooked. This early or "primary phase" involves the immediate reaction of the coronary circulation and its resultant effect on the entire myocardium. It represents a condition of acute coronary insufficiency or acute deprivation of myocardial blood supply. Instead of stating that the electrocardiographic pattern following pulmonary embolism is a classic example of changes due to "unilateral ventricular strain" we must not forget the first few minutes of the condition. During these minutes the primary pattern is one of generalized myocardial anoxia which soon develops the true pattern of acute cor pulmonale.

## CONCLUSIONS

The clinical syndrome of acute cor pulmonale is an established fact. The electrocardiographic findings will be misleading unless the condition is divided into separate and distinct phases.

1. Phase i. Which comprises the first few minutes of the accident with changes, due primarily to anoxia of the entire myocardium.

2. Phase ii. The subsequent tracings show true evidence of unilateral ventricular failure (right heart failure).

## SUMMARY

A case of acute cor pulmonale is presented with E. C. G. tracings taken within five minutes of the accident.

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## PENICILLIN FOR MENINGOCOCCEMIA

The prompt administration of penicillin in the case of a Waterhouse-Friderichsen syndrome (a sudden and severe infection due to the presence of meningococcic bacteria) accounts for at least one favorable recovery, J. M. Hayes, M.D., Los Angeles, and John F. Whalen, M.D., Altadena, Calif., report in *The Journal of the American Medical Association* for March 17. With the increasing prevalence of meningococcic meningitis there also has been an associated rise in the number of cases of the so-called Waterhouse-Friderichsen syndrome. Much excellent work has been done about this disease by Dr. Martland.

# MODERN CONCEPTS IN CLINICAL HEMATOLOGY AS REVEALED BY PERIPHERAL, BONE-MARROW AND SPLENIC ASPIRATIONS *

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Hematology proper concerns itself mainly with the study of the cytological elements of the blood and blood-forming organs as well as the blood-destroying organs. Actually, it involves a study of the hemolytopoietic activity of the reticulo-endothelial system. Studies have gone on in this system since it was popularized, not so long ago, by Aschoff. The reticulo-endothelial system is virtually a family of cells of similar potentialities. These cells abound for the most part in the bone marrow, spleen, liver, lymph nodes and to a lesser extent in the adrenal, pituitary, kidney and hemo-lymph nodes. In each organ these cells seem to specialize in a different activity of a well ordered process. In the bone marrow they form granulocytes (polys.); and red cells, and also lymphocytes, monocytes and plasma cells. In the spleen they, primarily, destroy red cells, but also granulocytes; red cells may be formed here whenever extra-medullary hematopoiesis becomes necessary. The spleen, besides destroying red cells, also takes part in the orderly destruction of granulocyteic elements, lymphocytes and platelets. It also manufactures lymphocytes and monocytes, and probably takes part in the formation of platelets.

In the liver the well-known Kupffer cells are part of the reticulo-endothelial system. The liver may make red cells and granulocytes under conditions of stress, i. e., extra-medullary hematopoiesis, and also takes part in the destruction of red cells.

It appears that each unit of the reticulo-endothelial system, while doing one thing primarily, is able to take on a bilateral or trilateral function, if the occasion arises. This, indeed, is fortunate, for if one part of the system falters, the other or supplementary organs can take over and save the day. This action is exemplified in leukemia, agranulocytosis, hemolytic icterus, benzol poisoning, polycytemia vera, etc.

The simplest approach to clinical hematology is via the blood smear. Here one notes the finished products, both productive and destructive of the hemolytopoietic system. A perusal of the peripheral smear shows the red cell, the white cell and the platelet. A study of these mirrors the activity of the primary and secondary hemolytopoietic centers.

Let us look at the red cells and see what information one may gather. It is possible to determine here, evidences of iron deficiency, E. M. F. (erythrocytic maturing factor) deficiency, hemolysis, regeneration of red blood cells as well as the presence of peculiar or atypical red cells significant of a primary intrinsic change in its nature. Among these may be listed the sickle cells, the "Cooley" cell, the target cell, and the microspherocyte. Each of the latter is expressive of different erythrocytic habit, i. e., part of a disturbed red cell manufacture. These are usually congenital and/or familial.

The study of red cell size is significant in that it determines whether we are dealing with macrocytosis, an evidence of E. M. F. deficiency, or microcytosis, in which one may postulate Fe. deficiency. In the latter instance the presence of a large central halo (della) is another evidence of iron deficiency (anochromasia).

The study of the stroma of the red blood cells reveals evidence of hemolysis if the latter is mothy, lacey, vacuolated, degenerated or separated in discrete stromal agglutinations (target cells). Some of these stromal clusters are located centrally and therefore the designation "target cells". Other manifestations of hemolysis are poikilocytosis and schizocytosis. These manifestations of hemolysis, microscopic to be sure, are forerunners of later changes, chemical in nature, which are expressed by the

* Read before the Bergen County Medical Society, March 13, 1945.

icterus index, and Van den Bergh determinations.

The smear is important because it yields evidence of red cell regeneration. What are the signs of red cell regeneration? An early or immature red cell is a sign of regeneration. It must be remembered that regeneration is an effort on the part of the bone marrow or other eythropoietic centre to produce new red cells to compensate for cells lost by hemorrhage or destroyed because of hemolysis (group incompatibilities; vulnerable red cells—microspherocytes, sickle cells, Cooley cells, target cells, schizocytes, poikilocytes, etc.), malignancy, infection or toxemia.

It will be noted, that all things being equal, for each cell destroyed, there is an effort on the part of the bone marrow or other hemtopoietic centres to compensate by replacing another. This laudable effort, however, does not always succeed and thus we are confronted with an hemolytic anemia, albeit with regeneration unequal to the task. It thus becomes a question of balance.

If hemolysis or hemorrhage equals regeneration we have no problem; if hemolysis and/or hemorrhage is greater than regeneration then we have anemia. If production is greater than destruction we have erythrocytosis or polycythemia (erythremia).

After we have examined the red cells and determined the various possible changes and their implications, above noted, we can turn our attention to the white cells. It is not necessary, here, to dwell, at length, on the routine differential. Beside the leukocytosis (polynucleosis), lymphocytosis, monocytosis and eosinophilia, we may also note their opposites, leukopenia (agranulocytosis), lymphopenia; monocytopenia, and eosinopenia. The latter, we shall not discuss here, since it would lead us far afield at this time. I should like to stress, however, a few points about our friend the "poly". It may have irregularly stained granules, and it may be vacuolated (toxic polys.); it may be very large (giant polys of pernicious anemia); it may be many-lobed (as in pernicious anemia); it may be single lobed (staff cell); its nucleus may be rounded up and/or deformed (Pelger's anomaly). To summarize, one may say that we may discern evidence of infection; polynucleosis (toxic polys), toxemia, or hemorrhage (polynucleosis), allergy (eosinophilia), left shift (staff cells and other immature cells). Also we may get the first inkling of obscure conditions (Pelger's anomaly) or other unsuspected conditions (pernicious anemia), by close attention to the polymorphonuclear cell.

The lymphocytes are not usually given the attention they deserve. They pass off with a brief percentage number. And yet the information they can yield is sometimes very useful. Usually we note small and large lymphocytes. Their size is not of practical value. It must be noted, however, that in children the large forms are found in great numbers, whereas in the adult the opposite is true. Thus if in an adult there is an increase of large lymphocytes, one should make an effort to look for something atypical.

Ofttimes such a search will be rewarded by finding—a large lymphocyte with a large ripe nucleus (usually indented), and abundant basophilic (immature) cytoplasm. This is the cell which I call the I. M. (Infectious Mononucleosis) cell. It is possible usually to identify these cells in cases of undoubted (heterophile positive) Infectious Mononucleosis. With more experience these cells have been noted even in heterophile negative, but otherwise clinically positive cases.

I should like to call attention to another important finding, and that is the smudge. Smudges are clusters of degenerated cells (lifeless) which are usually lymphatic in character, but may also be myelogenous in character. The former are seen in whooping cough, lymphatic leukemia, before and after x-ray therapy. The latter are found in acute and chronic myelogenous leukemia, and before and after x-ray therapy. Smudges of either type may be found in any condition after x-ray irradiation. Sometimes one may note characteristic lipoid vacuolization in lymphocytes. The latter are diagnostic of Niemann-Pick's disease.

After we have studied the white blood cells on the smear, we may next turn our attention to the platelets. These are small (2-3 micro.)

azurophilic bodies, usually rounded, appearing in clusters because of their stick-to-it-iveness or agglutinative capacity. In my experience it is futile to count them; all methods, at best, are impractical and unscientific, because of their sticky quality already referred to. Each laboratory has its own set of normals, depending on the method in use. It is our practice to use the stained smear to observe them, and to note their number while doing the usual smear study. If many clusters are present we call it 4 plus (corresponding to approximately 400,000 or over per ccm.). If a moderate number are present, we label it 3 plus (corresponding to approximately 300,000 per ccm.); if less are found (one or two platelets per field) it is 2 plus (or 200,000). If still less are found (an occasional platelet in a field or every other field) it is one plus (or 100,000). If an occasional platelet is found on the slide it is one plus or 0 (less than 100,000).

Not only are we concerned with the number of platelets, but we are concerned with their character. We want to know whether they are in clusters or discrete; whether they are equal in size and shape; whether they are large or small, well formed or deformed. Each consideration has definite implications.

If they are discrete there is a suspicion of lack of stickiness (evidence of a hemorrhagic tendency). If they appear in clusters, it means that the agglutinative power is evident. If there is an excess in size and number of clusters it is an evidence of hyperagglutination (after hemorrhage; post splenectomy, after anesthesia, during infection).

If there are giant platelets (gigantothrombia) or unusually small platelets (microthrombia) or deformed platelets (poikilothrombia) one must postulate a disturbed platelet mechanism and a study of the megakaryocytes in the bone marrow will then reveal the true nature of the process. If the spleen destroys platelets (splenic thrombocytolysis) as in Idiopathic Purpura Hemorrhagica (Essential Thrombocytopenia) then the bone marrow will reveal an increased number of megakaryocytes (a compensatory megakaryocytosis) to make up for the platelets destroyed or lost. The megakaryocytes will be found to be immature or mature, and some may even undergo degeneration, because they have overstayed their welcome in a useless existence. It appears that the megakaryocyte will give birth to platelets only when it is mature, and if there is no maturing substance available, it will die from a "disuse atrophy".

At other times the increased megakaryocytic activity will give rise to the abnormally formed platelets already referred to (poikilothrombia). In certain conditions of thrombocytopenia, the megakaryocytes may or may not be diminished; this may be seen in scurvy. It is necessary to point out that scurvey may be present with or without thrombocytopenia. Benzol poisoning, aplastic anemia, Gaucher's disease, acute leukemia, all show thrombocytopenia, but here the megakaryocytes in the bone marrow are invariably reduced. Thus, it may be seen what a wealth of information may be gleaned by a study of the platelets, in its evaluation of the hemorrhagic diatheses.

A study of the smear as you have noted is capable of yielding information about the red cells, and its iron and E. M. F. deficiencies, hemolysis and regeneration; about the white blood cells as an evidence of infection, toxemia, destruction or left shift, and, also about the platelets with its information about every bleeding tendency.

In spite of the information afforded by a study of the smear, it is not uncommon to be left with a perplexing hematological question which is unanswered. Here, a study of the extra-medullary tissues may throw additional light on the clarification of the blood picture. It is a simple procedure to aspirate sternal marrow and even to perform a splenic puncture.

It might not be amiss therefore, at this time, to indicate conditions where bone marrow and splenic studies might be of assistance. Perhaps it would be best to hazard a classification of the indications for bone marrow and splenic studies:

1. Conditions where blood studies are not diagnostic but where the bone marrow is diagnostic:
   a. Gaucher's Disease
   b. Niemann-Pick Disease

c. Multiple myeloma
d. Metastasis to bone marrow
e. Osteosclerotic Anemia
f. Leukopenic or aleukemic Leukemia
g. Neutropenic Splenomegaly.

2. Conditions where bone marrow studies are confirmatory:
   a. Myeloblostic Leukemia
   b. Agranulocytosis
   c. Infectious Mononucleosis
   d. Lymphosarcomatosis
   e. Hodgkin's Disease
   f. Pernicious Anemia
   g. Hemolytic Icterus
   h. Cooley's Anemia
   i. Erythroblastosis
   j. Essential thrombocytopenic Purpura
   k. Leukemoid Reactions.

3. Conditions where the bone marrow clarifies the underlying physio-pathologic process:
   a. Erythroblastosis
   b. Polycythemia Vera
   c. Maturation defect in Red Cells
   d. Maturation arrest of the granulocytic series
   e. Absence or deterioration of the megakaryocytes
   f. Increase of megakaryocytes with or without immature forms.
   g. Study of plasma cells and plasmablasts
   h. Presence of histiocytic phagocytes.

4. Conditions where bone marrow studies may be uninformative yet the spleen may point to an explanation:
   a. Gaucher's Disease
   b. Niemann-Pick Disease
   c. Polycythemia Vera
   d. Lymphosarcomatosis.

It will be obvious from a study of the above classification that much progress has been made in hematology since the advent of the bone marrow aspiration from the sternum. The procedure has proven innocuous in the hands of all hematologists. Sternal aspiration in our experience is never contra-indicated in any medical condition, where the hematological conditions warrant it. Such conditions as cardiac decompensation, coronary thrombosis, pneumonia, severe anemia, liver damage, renal failure, pericarditis, none of these should be a deterrent, if a sternal puncture becomes necessary.

In summary, clinical hematology may derive a great deal of benefit from the study of the simple stained blood smear; the bone marrow has afforded much light both as a confirmatory agent and as a pathfinder in blood diseases. The spleen has helped to fill in the gaps where the bone marrow left us bewildered. However, a word of caution is necessary here. The data obtained by a study of all hematologic aspects of a case should never be sufficient to make a diagnosis. A complete history and a thorough physical examination is still the sine qua non into which all hematologic findings must fit. A diagnosis cannot be left to a set of figures, no matter how accurately arrived at, without the patient himself, the cynosure of all our procedures. We have to note the glossitis in Pernicious Anemia. We have to feel the lymph nodes in lymphatic leukemia and Hodgkin's disease and lymphosarcoma. We have to feel the spleen in leukemia, hemolytic icterus and polycythemia vera. We have to see the petechiae in the purpuras; we have to see the necrotic ulcerations in the mouth in agranulocytosis and acute leukemia. The clinical picture remains the most important consideration in all hematologic investigations.

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## BORIC ACID OINTMENT INTOXICATION

Boric acid, whether applied in the form of an ointment or a saturated solution to extensive wounds, is a cumulative poison. The weak antiseptic value of boric acid suggests that for medicinal use other more active and less potentially harmful therapeutic agents should be employed — Pfeiffer et al., J. A. M. A., Vol. 128, No. 4, p. 266.

# STATE ACTIVITIES

## SYNOPSIS ON SCHISTOSOMIASIS

by Committee on Tropical Diseases, CHRISTIAN P. SEGARD, Chairman
ARTURO R. CASILLI, FRANK ALTSCHUL, SARITA DE PONS

Since the last report of the Committee (Journal of Medical Society, N. J., Vol. 42, No. 1, page 22, [Jan.] 1945) another tropical disease has received widespread notice. The Committee is therefore bringing it to the attention of the members.

Schistosomiasis (Bilharziasis) is a subtropical or tropical disease caused by one or more of the three blood flat-worms or flukes, *Schistosoma japonicum, Schistosoma haematobium,* and *Schistosoma mansoni.*

The worms live in the blood vessels of the primary host, man, and in the case of *S. japonicum* also in domestic animals.

The worms insert their eggs in the walls of the capillaries and the eggs move through the tissues into the lumen of the intestine or bladder to be passed out in the feces or the urine. *S. mansoni* and *S. japonicum* are usually discharged into the intestines and *S. haematobium* into the bladder.

If the egg reaches water, it releases the first larval worm, which is called the miracidium (little boy). The miracidium has an effectual lifetime of from eight to twelve hours in which it must find and enter its specific snail host or die. It may live as long as 54 hours but it is usually unable to penetrate the snail after twelve hours.

In the snail host (vector) it multiplies thousands of times and the forked-tailed larvae (cercariae) which pass from the snail into the water are infective to man if he enters the water or even if water containing cercariae splashes on to the skin and is not immediately wiped dry. Men should be gravely warned to keep away from raw water in infective areas. One or another of the three schistosomes are endemic in the following regions:

*S. japonicum*—China, Japan, Formosa, the Philippine Islands, The Celebes and the Near East, Egypt, Anglo-Egyptian Sudan, most of Central Africa, the Coastal Countries of Africa, Madagascar and Mauritius as well as the North African Coast.

*S. haematobium* is common in Africa, Syria, and Iraq.

*S. Mansoni* is common in Africa, in certain parts, and in certain parts of West Indies and in Northern South America.

The disease cannot be passed from man to man but must go from man to snail and then back to man.

### OUTLINE OF THE LIFE CYCLE OF ALL THE SCHISTOSOMES

Adult worm in man—eggs incubated in man and passed into water—eggs open freeing the miracidium—miracidium enters snail, multiplies and emerges into the water as the cercaria—cercaria enters man through the unbroken skin, migrates to the liver, becomes adult, copulates, goes in copula to the site of predilection to lay eggs and start the cycle all over again.

### THE TIMES INVOLVED IN THE LIFE CYCLE

Adult worm in man lives more than 20 years; probably as long as man lives after infection.

Eggs mature in 10 to 20 days and are usually mature when passed. In water they open in ½ to 4 hours according to the temperature. Miracidium lives 54 hours but can penetrate snails only from 8 to 12 hours. Larval life and multiplication in the snail is from 8 to 10 months, in some cases as long as the snail lives which is about 14 months. Cercariae begin to leave the snail in from 2 to 6 weeks depending upon the temperature. Only from 8 to 12 hours are they effectual at entering the skin so it renders water safe for bathing if it is allowed to stand for 36 hours. Entry through the skin may take place in as short a time as 15 seconds. Development to sexual maturity takes from 3 weeks to as long as 3 months.

Entrance of the cercariae through the skin causes a sharp nettle-like sting, followed by a severe itching dermatitis. After the cercaria has entered the dermis no disinfectant applied to the skin has any deterrent effect upon the larval worm.

Development of the larval worm in the liver causes cirrhosis. Migration of the adult worm to the site of predilection may be accompanied with fever. Discharge of eggs by the adult female worm into the intestinal and bladder

mucosa causes irritation and ulceration. The eggs are usually mature when they are discharged into the intestinal lumen or into the bladder. In the intestine the eggs do not usually mix intimately with the feces but are found in a bloody mucous envelope at the lower end of the formed stool. Rectal fistulae are often seen as a result of egg deposition. *S. haematobium* produces secondary changes of the kidneys, ulceration of the ureters, predisposes to formation of stone in the ureters, bladder, and urethra, ulceration of the bladder and secondary degenerative carcinoma.

In the early stage a history of exposure is a most important clue to the diagnosis. The symptoms, except in massive infestations, are mild fever, mucous dysentery, haematuria, frequent and painful urination and tenesmus. The clinical findings of outstanding significance are urticaria, itching, fever, cough, diarrhea, palpable liver, and later palpable spleen. Schistosomiasis may be confused with other febrile diseases such as dengue, malaria, kalaazar, typhoid fever, and tuberculosis.

A positive diagnosis is made by finding eggs in the stool or urine or other exudates. *S. japonicum* eggs are smaller and rounder than the other two and there is a little knob on one side of the eggs. *S. mansoni* is the largest egg and has a large spur on the side of the egg just below midline. *S. haematobium* is large and ovoid and has a terminal spine.

All patients coming from a schistosome area and showing symptoms should be examined frequently over a period of months in order to arrive at a positive diagnosis or else to exclude schistosomiasis. Suspected carriers should be warned never to pollute water.

People going into schistosome areas should never expose themselves to untreated water even though it appears clean and clear. Cercariae can enter through the unbroken skin in as short a time as 15 seconds. Cercariae enter the skin below the surface of the water as often as they do on the surface film.

Treatment is usually effective in killing the adults and the ova. It will not alter the fibrotic changes. It must be persisted in for the full course.

Potassium-antimony-tartrate (P.-A.-T.) or tartar emetic has been used. The initial dose of 0.03 gm. (30 mgm.) is administered intravenously in fresh 2 per cent distilled water solution. Every other day it is increased by 0.03 gm. until 0.10 to 0.15 gm. dosage is reached. *This dosage* is continued until 1.50 gm. to 2.00 gms. have been given. The greatest care must be taken not to inject any of the solution into the tissues or very severe sloughing may result. If there is vomiting during the injection the dosage should be reduced. Coughing during injection is a common and unimportant symptom.

Fuadin intramuscularly is often used in schistosomiasis infections. It is most effective against *S. haematobium*. It is given intramuscularly in 6.3 per cent distilled water solution. Adult dosage is 1.5 cc., 3.5 cc., and 5 cc. on successive days, then 5 cc. every other day for 18 days or until 50 cc. have been given. It may be necessary to repeat the course after an interval of 2 to 3 weeks if cure is not complete.

Anthiomaline 6 per cent distilled water solution intramuscularly beginning with 1 cc. and increasing to 3 cc. till 50 cc. have been effectively given over a period of 30 days. Too frequent administration may cause antimony arthritis, malaise and edema of the feet and legs.

While schistosomiasis is not a reportable disease in New Jersey, the State Department of Health should receive notification.

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## PUBLIC RELATIONS

As part of the public relations program of the Society, sixteen electrical transcriptions are being broadcasted over four New Jersey radio stations.

The series, titled "Before the Doctor Comes", gives expert and practical suggestions as to the ways and means of dealing with common ailments in the home before the doctor comes.

The schedule of broadcasts is as follows:

Station WFPG, Atlantic City, each Sunday, at 4 p. m.
Station WTTM, Trenton, each Friday, at 1 p. m.
Station WAAT, Newark, each Sunday, at 10 a. m.
Station WPAT, Paterson, each Sunday, at 10 a. m.

Listen in, and give us your reactions to these programs as a public relations effort.

## 180th ANNUAL MEETING — MAY 21, 22 and 23, 1946
## CLARIDGE HOTEL, ATLANTIC CITY

With all convention restrictions lifted, the Committee on Annual Meeting is arranging a full three-day program of House of Delegates Meetings, General Sessions, Scientific Section Meetings, Banquet and Commercial Exhibits. Come and bring your family.

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## MEETING OF THE BOARD OF TRUSTEES

A regular meeting of the Board of Trustees was held at 2:00 p. m. at the State Society Headquarters in Trenton on Sunday, October 21, 1945.

Chairman Norton presided. Those present were: Dr. Norton, Dr. Alexander, Dr. Stahl, Dr. North, Dr. McBride, Dr. Hawkes, Dr. Scammell, Dr. Fithian, Dr. Green, Dr. Coleman, Dr. Hornberger, Dr. Schaaf, Dr. Londrigan, Dr. Young, Dr. Crowe, Dr. Costello, Dr. Dodd and Dr. Lee. Also present upon invitation were: Dr. Sica, Dr. Hollinshed, Dr. Barkhorn, Dr. Lewis, Dr. Scott, Dr. Johnsen and Dr. Donohoe.

### JUNE 24TH MINUTES

The minutes of the regular meeting of the Board on June 24, 1945, were approved.

### MEDICAL DIRECTOR, WORKMEN'S COMPENSATION

In response to a request from Commissioner Harper of the Department of Labor for a list of qualified physicians to be considered in the appointment of a full-time Medical Director of the Workmen's Compensation Bureau, Dr. Alexander, Dr. Scammell and Dr. Londrigan were appointed as a committee from the Board with power to act to conduct negotiations for the Board with Commissioner Harper in the consideration of physicians qualified for the appointment; the committee to review all applications and make recommendations themselves if they so desire; the committee to contact each county society requesting that names of qualified physicians be submitted.

### BOARD OF MEDICAL EXAMINERS

The names of the following candidates—Dr. Patrick H. Corrigan, Trenton, Dr. Anthony J. Conty, Union City, and Dr. George J. Young, Morristown—were recommended for consideration of Governor Edge in the appointment of a member on the State Board of Medical Examiners.

### HONORARY MEMBER

The Medical-Surgical Plan of New Jersey recommended Mr. John S. Thompson, member of the Board of Governors and Secretary of the Medical Service Administration and member of the Board of Trustees and Secretary-Treasurer of the Medical-Surgical Plan, for honorary membership in The Medical Society of New Jersey. President Alexander was instructed to reply to the communication indicating that the Society sincerely regrets its inability to comply with the suggestion, in view of the provisions of the Constitution, Article IV, Section 5, "Honorary Members shall be physicians and surgeons . . ."

### LETTER FROM PASSAIC COUNTY MEDICAL SOCIETY

The Board considered a communication from the Passaic County Medical Society relative to the application of a physician to that Society who had previously been expelled from membership in another Society following conviction on charges of larceny.

It was directed that the matter be referred back to the Passaic Society for action on the application and explaining the channels through which the Society or the applicant can proceed after such action if either party is not satisfied.

### BABY SAFETY FOLDER

The Board approved the endorsement of the Baby Safety Folder of the Newark Safety Council by the Advisory Committee to the Woman's Auxiliary and the Advisory Committee on Child Health.

### AUDIT COMMITTEE

Dr. McBride, Dr. North and Dr. Scammell were appointed as an Audit Committee to consider the audit of the State Society Books for the year June 1, 1944-May 31, 1945.

### A. M. A. HOUSE OF DELEGATES MEETING, 1945

The Board authorized President Alexander and Dr. Scott to attend the 1945 meeting of the A. M. A. House of Delegates, December 3-6, in Chicago, as unofficial representatives of The Medical Society of New Jersey and at the expense of the Society.

It was directed that in the event a Delegate

and his designated Alternate cannot attend that Dr. Snedecor, an elected Alternate, attend the meeting.

### MEDICAL CARE OF THE VETERAN

At the request of the New Jersey Delegates to the A. M. A. for a broad outline of the philosophy of the State Society relative to matters connected with the returning veteran, the Board referred the request to a Committee of five—Dr. Alexander, Dr. Hawkes, Dr. Lee, Dr. Schaaf and Dr. Scammell—the Committee to choose its own Chairman—to determine this philosophy and to act as liaison between this Society and the Veterans Bureau in all matters concerning the veteran. It was suggested that the Committee work with the Medical Practice Committee, the Committee on the Distribution of Medical Care (including Veterans) and the A. M. A. Delegates to draw up a flexible plan of guidance to give the Delegates a basis for discussion at the A. M. A. meeting in December.

The Board approved the action of the Medical Practice Committee on October 7th with regard to the Veterans Bureau making contracts with local hospitals—"That to meet the emergency, because it is our sense that these patients get hospital and medical care, we go on record as approving the hospitals making the contract to include hospital care, and that the arrangements for the doctor be made on a fee for case basis between the participating doctor and the Veterans Administration."

### PHYSICIAN-VETERANS

The Board took action to request each County Medical Society to set up a committee to handle the problems of physician-veterans.

### REPORT OF THE PRESIDENT

*Survey of Hospitals and Health Center Facilities*

President Alexander announced he had appointed the following committee to serve in an advisory capacity to Dr. Emil Frankel, Director of the Survey of Hospitals and Health Center Facilities, under the State Commission on Post-War Economic Welfare; the committee to work in conjunction with the State Departments of Health and Institutions and Agencies:

Dr. Watson B. Morris, Chairman, Springfield
Dr. Stanley Nichols, Long Branch
Dr. L. Samuel Sica, Trenton
Dr. Harrison B. Wilson, Hackensack
Dr. Charles Hyman, Atlantic City
Dr. Russell K. Tether, Closter
Dr. J. Harris Underwood, Woodbury
Dr. Norman M. Scott, Consultant, Newark

*Commission on Post-War Economic Welfare*

At the request of Judge Howard Eastwood, Chairman of the Commission, for a representative of The Medical Society of New Jersey to serve on the Survey Committee, Dr. Frederic J. Quigley, Union City, was appointed by President Alexander.

*1946 Annual Meeting*

The Board approved the dates of May 21-23, 1946, for the 180th Annual Meeting to be held at The Claridge Hotel, Atlantic City.

*Crippled Children's Commission*

At the request of the New Jersey Crippled Children's Commission, President Alexander accepted appointment as a member of the Advisory Committee to the Commission.

*Advisory Committee, Workmen's Compensation*

At the request of Commissioner Harper, Department of Labor, for another member of the Advisory Committee on Workmen's Compensation in place of Dr. Costello, resigned, President Alexander appointed Dr. J. Irving Fort of Newark. Subsequently Dr. Alexander appointed Dr. Marcus H. Greifinger of Newark to serve in place of Dr. Fort until the latter has recovered from an illness and is able to resume his duties.

*Public Relations Conference*

President Alexander reported that Dr. Quigley had attended a Conference on Public Relations as his representative, together with Dr. Sica and Dr. Scott as representatives of the Public Relations Committee. The Conference was called by the Council on Medical Service and Public Relations of the A. M. A. for October 19th and 20th in Chicago.

The report of the President was approved by the Board.

### EXECUTIVE OFFICER

Following discussion relative to the desirability and necessity for securing an Executive Officer for the State Society, the Board directed that a committee of five be appointed by the Chairman to interview and recommend applicants for appointment as Executive Officer.

### HOUSE COMMITTEE

The detailed report of the House Committee on the expenses incurred in the renovation of and equipment for the home of the Society was received and placed on file, and the Committee authorized to incur additional expenses up to the amount of $3,600.

The Board directed that the contribution of $4,000 from the Mercer County Medical Society for use in defraying the costs of the renovation of the auditorium be acknowledged.

### PROGRESS REPORTS

Progress reports from the Committee on Intern Training and the Committee on Osteopathic Problems were received and placed on file.

### WELFARE COMMITTEE

The reports of the Welfare and its Subcommittees were approved (p. 366).

### ALBERT C. WALL, ESQ.

The following resolutions on the death of Albert C. Wall, Esq., late Counsel for the State Society, were adopted by the Board and ordered sent to the family of Mr. Wall:

"With profound sorrow, the Trustees and Component Societies of The Medical Society of New Jersey record the death of one of its most earnest and zealous friends—Albert C. Wall. Mr. Wall had been counsel to the Society for twenty-five years, during which he was always ready to advance its usefulness by wise counsel and enthusiasm for its aims. He had a great affection and respect for the medical profession. This gave him a high conception of the mission of the profession in enlightening and safeguarding democracy.

"Mr. Wall was a learned man, not only in the law, but he had a large fund of general information and a splendid philosophy of life which made his counsel particularly helpful. He was a man of great charm. He headed one of the truly great legal firms in the state and was a very busy man, still, he was always ready to see any Committee of The Medical Society of New Jersey at short notice, and promptly to give or write an opinion on any matter that was brought to his attention. We have lost a great and good friend, his place in the community will be hard to fill. With the sense of our loss is mingled deep sympathy for his family."

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## WELFARE MEETING

A meeting of the Welfare Committee was held at the Headquarters of the State Society, Trenton, on Sunday, October 7, 1945. Dr. Sigurd W. Johnsen, Chairman, presided.

A total attendance of 95 included 45 members of the Committee and 50 guests representing the A. M. A. Delegates, Trustees, County Society Officers and Woman's Auxiliary. Representatives from the Medical Societies of Rhode Island, Connecticut and Pennsylvania were also present.

### ATTENDANCE

Sigurd W. Johnsen, Chairman
Herschel S. Murphy, Vice-Chairman
Samuel Alexander, President
Alfred Stahl, Secretary

Atlantic—David B. Allman, D. Ward Scanlan
Bergen—Floyd E. Keir, William K. Harryman
Camden—Henry B. Decker, H. Wesley Jack
Cape May—George F. Dandois
Cumberland—H. Burton Walker, Albert H. Kump
Essex—Harrold A. Murray, H. Roy Van Ness, Harry N. Comando, William D. Crecca, Marcus H. Greifinger, Walter G. Alexander, J. Wallace Hurff
Gloucester—Wendell J. Burkett, Chester I. Ulmer
Hudson—Reeve L. Ballinger, Berthold S. Pollak, J. Lawrence Evans
Hunterdon—Barclay S. Fuhrmann
Mercer—Walter E. D'Arcy, D. Leo Haggerty, L. Samuel Sica
Middlesex—Joseph H. Kler, William C. Wilentz, Ralph J. Faulkingham
Monmouth—Stanley Nichols
Morris—Stanley Teskey, Daniel W. Teller, Jr.
Ocean—William E. Dodd
Passaic—H. Hale Hollingsworth
Salem—Harry F. Suter
Somerset—Lewis C. Fritts
Sussex—Martin E. Kirschner
Union—Frederic W. Lathrop, Thomas J. Walsh
Consultants—Frederic J. Quigley, Emil Frankel, Ph.D.; Mr. John J. Debus

Guests—Mr. J. W. Holloway, Jr., A. M. A.; Joseph F. Lawrence, A. M. A.; Joseph H. Howard, Connecticut; Creighton Barker, Connecticut; James R. Miller, Connecticut; C. L. Palmer, Pennsylvania; Mr. John E. Farrell, Rhode Island; Lucius F. Donohoe, Andrew F. McBride, Lancelot Ely, Spencer T. Snedecor, E. Zeh Hawkes, Watson B. Morris, Thomas K. Lewis, Joseph F. Londrigan, Arthur P. Hasking, Andrew C. Ruoff, Andrew C. Ruoff, III; J. O. Hill, Theodore R. Robie, Royal A. Schaaf, Elmer P. Weigel, Charles Hyman, Julius Levy, Arthur B. Peacock, H. C. Burkhead, Abraham E. Jaffin, H. E. Reading, Granville L. Jones, S. William Kalb, Joseph G. Coleman, Norman M. Scott, Walter F. Phelan, Joseph A. Lepree, William Rumsey, A. Charles Zehnder, Christian P. Segard, Frederick G. Wandall, Baxter A. Livengood, J. Mallory Carlisle, Walter B. Mount, Rudolph C. Schretzmann, Mr. H. A. Borchert, Miss Evelyn T. Walker, R.N.; Miss Louise Rogers, Mrs. William E. Dodd, Mrs. David B. Allman, Mrs. Frederick G. Wandall, Mrs. Andrew C. Ruoff, Mrs. Andrew C .Ruoff, III.

President Alexander introduced the guest speakers:

Mr. J. W. Holloway, Jr., Director of the Bureau of Legal Medicine and Legislation of the American Medical Association, "The Future Prospects of the Wagner-Murray-Dingell Bill".

Dr. Joseph S. Lawrence, Director of the Washington Office of the American Medical Association, "The Constructive Program of the American Medical Association for American Medical Service".

REPORTS OF SUB-COMMITTEES

*Legislation*

Dr. Pollak, Chairman, presented a report on Federal and State Legislation.

Federal Legislation—Twenty-four hundred copies of the analysis of the public health and medical aspects of the Wagner-Murray-Dingell Bill, which appeared in the July issue of *The Journal*, were distributed to various officials and organizations including the New Jersey representatives in Congress. Replies from both Senators and eleven of the fourteen Representatives indicated a distinct favorable reaction to our point of view.

The Pepper Bill would make permanent the war EMIC program.

The Hill-Burton Hospital Construction Act —the subjoined extracts of criticism of Title VI of the Wagner Bill (p. 209, July Journal) may be applied with equal validity to this act.

Senate 178 would amend the U. S. Employees Compensation Act to permit chiropractors to treat beneficiaries of the Act. A Senate Committee hearing on this bill was held on June 13th at which Dr. Quigley appeared; no action has yet been announced.

State Legislation — Reorganization of the State Department of Health; in the main the bill introduced the last day of the Legislature conformed closely with the recommendations submitted by President Alexander at a hearing on the tentative draft of the bill last winter.

The chiropodists, through the Chiropodists' Society of New Jersey, have been pressing for consideration of the idea of that group having representation on the Board of Medical Examiners, and have asked that a committee of three from the Legislative Committee meet with a similar committee of the Chiropodists' Society to discuss the matter. Drs. Alexander, Pollak and Quigley were appointed to meet with the chiropodists.

The report of the Legislative Committee was unanimously adopted.

*Medical Practice*

Dr. Carlisle, Vice-Chairman, reported his Committee had approved a resolution adopted by the Joint Committee on Professional Relations concerning the increasing number of names of new pharmaceutical products of the many drug manufacturers in our country. The resolution is an effort to simplify medical nomenclature of proprietary medications wherever possible by limiting identification of such products to firm names; and the resolution is to be brought to the attention of the A. M. A. and the American Pharmaceutical Association requesting a joint study of the matter.

The resolution was unanimously adopted.

Two plans for the examining and treating of veterans in New Jersey (the Monmouth County Plan and Major Fagley's Plan) were presented with the recommendation that they be submitted to the County Medical Societies for study. A third plan, the Connecticut Plan, was described by the President of the Connecticut State Medical Society.

Upon unanimous action it was directed that copies of all three plans for the examination and treatment of veterans be forwarded to the County Medical Societies for study with the view of formulating a state-wide plan which will meet the needs of all counties.

Relative to the advertisement of the Latex Company in Delaware, which lauds the Pepper Bill and states that the doctors are entirely satisfied with the EMIC program, the Committee adopted a recommendation that the Board of Trustees of the A. M. A. be requested to write to the Latex Company pointing out to them that their advertisement in the newspapers from coast to coast on the Pepper Bill for maternal and infant care gives an erroneous impression to the public when they state that the EMIC program is satisfactory to the doctors, and calling to their attention that this is not a true statement of fact; and further that President Alexander write to the Latex Company telling them that The Medical Society of New Jersey disapproves of this misstatement of fact.

A summary of the questionnaire distributed to each County Medical Society on Medical Care of the Indigent and the Low-Wage Group was received (p. 348).

*Public Health*

Dr. Nichols, Chairman, reported that there is over $100,000 for use in New Jersey by the Cancer Society. The following recommendations were adopted:

1. That the New Jersey Division of the American Cancer Society finance a

state-wide survey of individual counties and the state as a whole as to their needs in regard to the terminal care of the cancer patient.

2. That a conference be set up by official delegates of The Medical Society of New Jersey, the New Jersey Division of the American Cancer Society, the New Jersey Division of the Women's Field Army, and the State Departments of Health and Institutions and Agencies, to consider the establishment of a State Cancer Committee with carefully defined functions.

The "Ten Beliefs of Organized Medicine as to Medical Care" (p. 349) were approved.

*Public Relations*

Dr. Sica, Chairman, announced that Dr. Scott, in his capacity as Executive Assistant, had been assigned and had accepted the position of Executive Secretary to the Sub-Committee on Public Relations.

The following steps have been taken in inaugurating a Public Relations Program:

1. Radio Broadcasts—Through the five major New Jersey broadcasting stations, starting November 1st, a series of sixteen ten-minute health broadcasts will be presented. The broadcasts are electrical transcriptions borrowed from the Bureau of Health Education of the American Medical Association.

2. County Public Relations Committees—Each County Society has been requested to appoint a local committee if one does not already exist, through which the State Committee can work.

3. Speakers' Bureau — The formation of this bureau will be undertaken by a member of the Committee, Dr. Kler.

Dr. Sica and Dr. Scott were designated as representatives of the Public Relations Committee to attend the preliminary meeting of the New Jersey Society of Professional Engineers with a view to forming a mutual protective organization without definite commitment from The Medical Society of New Jersey.

The report was unanimously approved.

SIGURD W. JOHNSEN, M.D.,
Chairman.

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## NUTRITION IN EVERYDAY PRACTICE

S. WILLIAM KALB, M.D., Newark, N. J.
Nutrition Representative, Tuberculosis and Adult Disease Control Advisory Committee to the Subcommittee on Public Health

### COUNTING CALORIES FOR THE HOLIDAYS

| MEAT AND FISH | CALORIES | PORTION |
|---|---|---|
| Beef, boiled | 490 | ½-lb. |
| Beef steak, round, broiled | 362 | ½-lb. |
| Beef steak, sirloin, broiled | 404 | ½-lb. |
| Beef, roast | 404 | ½-lb. |
| Chicken, boiled | 470 | ½-lb. |
| Chicken, broiled | 338 | ½-lb. |
| Chicken, fricasseed | 452 | ½-lb. |
| Chicken, roasted, dark meat | 396 | ½-lb. |
| Chicken, roasted, light meat | 318 | ½-lb. |
| Chicken, stewed | 270 | ½-lb. |
| Turkey, roasted, dark meat | 436 | ½-lb. |
| Turkey, roasted, light meat | 378 | ½-lb. |
| Ham, baked or boiled | 189 | ¼-lb. |
| Ham, smoked | 502 | ¼-ib. |
| Bluefish, broiled | 200 | ½-lb. |
| Clams, round, fresh | 156 | 1 cup |
| Cod steak, steamed | 200 | ½-lb. |
| Crabs, canned | 145 | 1 cup |
| Crabs, hard, cooked | 65 | 1 cup |
| Flounder, fried | 500 | ½-lb. |
| Halibut, steamed | 260 | ½-lb. |
| Herring | 152 | 1 fillet |
| Lobster, boiled | 90 | ½ |
| Mackerel, broiled | 300 | ½-lb. |
| Oysters | 16 | 1 med. |
| Salmon, canned | 200 | ½ cup |
| Scallops, fried | 225 | 1 cup |
| Shad | 454 | ½-lb. |
| Shad roe | 185 | ½ large |
| Shrimp, fresh | 7 | 1 |
| Sturgeon, smoked | 115 | ¼-lb. |
| Trout, brook, cooked | 264 | ½-lb. |
| Tuna, canned | 310 | 1 cup |
| White fish, fried | 490 | ½-lb. |

| DAIRY PRODUCTS | CALORIES | PORTION |
|---|---|---|
| Butter | 77 | 1 pat |
| Sour cream, heavy (40% fat) | 56 | 1 Tablesp. |
| Sour cream, light (20% fat) | 33 | 1 Tablesp. |
| Sweet cream, heavy (40% fat) | 100 | 1 Tablesp. |
| Sweet cream, light (20% fat) | 55 | 1 Tablesp. |
| Whipped cream (32% fat) | 46 | 1 Tablesp. |
| Egg, boiled | 84 | 1 av. |
| Egg, fried | 124 | 1 |
| Egg, poached | 83 | 1 |
| Egg, scrambled | 143 | 1 |
| Omelette | 321 | 1 |
| **CHEESE** | | |
| American | 440 | 2"x2"x1¼" |
| Camembert | 282 | 2¼"x2¼"x1" |
| Cottage, creamed | 828 | 1 cup |
| Cottage, skimmed | 235 | 1 cup |
| Cream | 125 | 1/3 package |
| Farmer's Pot Cheese | 412 | 1 cup |
| Roquefort | 121 | 1" cube |
| Swiss | 430 | 1 sl. 4"x4"x⅝" |
| **SOUPS** | | |
| Bouillon | 25 | 1 cup |
| Chicken noodle soup | 142 | 1 cup |
| Clam Chowder | 360 | 1 cup |
| Consomme | 5 | 1 cup |
| Creamed vegetable | 200 | 1 cup |
| Vegetable | 142 | 1 cup |
| **VEGETABLES** | | |
| Asparagus | 13 | 1 stalk |
| Beets | 83 | 1 cup |
| Broccoli | 44 | 1 cup |

| VEGETABLES | CALORIES | PORTION |
|---|---|---|
| Brussel sprouts | 34 | 1 cup |
| Cabbage, raw | 47 | 1 cup |
| Cabbage | 14 | 1 cup |
| Cauliflower | 30 | 1 cup |
| Carrots | 35 | 1 cup |
| Celery | 4 | 1 stalk |
| Chard | 27 | 1 cup |
| Cranberry sauce | 275 | ½ cup |
| Cucumbers, raw | 7 | 1 med. |
| Dandelion | 100 | 1 cup |
| Lettuce | 10 | 3 leaves |
| Mushrooms | 4 | 1 cup |
| Onions, raw | 26 | 1 med. |
| Onions, fried | 218 | ½ cup |
| Parsnips, boiled | 9 | 1 cup |
| Peas | 76 | 1 cup |
| Peppers, green, fresh | 30 | 1 med. |
| Scallion bulb | 3 | 1 sm. |
| Potato, white, boiled | 158 | 1 med. |
| Potato, white, baked | 166 | 1 med. |
| Potato, sweet, baked | 226 | 1 med. |
| Potato, french fried | 295 | 1 cup |
| Radishes | 2 | 1 med. |
| Sauerkraut | 46 | 1 cup |
| Spinach | 66 | 1 cup |
| Squash, summer | 27 | 1 cup |
| String beans | 195 | 1 cup |
| Tomato | 57 | 1 cup |
| Tomato, fresh | 36 | 1 med. |
| Turnip, yellow | 62 | 1 cup |
| **FRUIT** | | |
| Apple, raw | 106 | 1 med. |
| Banana, yellow | 138 | 1 med. |
| Dates, dried | 27 | 1 |
| Figs, fresh | 22 | 1 |
| Figs, dried | 59 | 1 |
| Grapes | 5 | 1 |
| Grapefruit | 29 | ½ fruit |
| Orange | 52 | 1 med. |
| Peach | 60 | 1 |
| Pears, fresh | 64 | 1 pared |
| Plum | 10 | 1 |
| Prunes, dried | 38 | 1 |
| Pineapple, fresh | 27 | 1 sl. |
| Strawberries | 4 | 1 |
| Tangerine | 38 | 1 med. |
| Watermelon | 150 | 1 slice |
| **BEVERAGES** | | |
| Milk, whole | 181 | 1 glass |
| Milk, skimmed by hand | 95 | 1 glass |
| Butter milk | 163 | 1 glass |
| Coffee, pulverized | 21 | 1 tablesp. |
| Coffee, roasted, ground | 17 | 1 tablesp. |
| Instant Postum | 23 | 1 tablesp. |
| Sarsaparilla soda | 115 | 1 glass |
| Seltzer | 0 | 1 glass |
| Cream soda | 120 | 1 glass |
| Orange soda | 117 | 1 glass |
| Raspberry soda | 118 | 1 glass |
| Coca Cola | 65 | 1 bottle |
| Ale | 150 | 1 glass |
| Applejack | 75 | 1 brandy glass |
| Beer | 117 | 1 glass |
| Brandy | 65 | 1 cordial glass |

| BEVERAGES | CALORIES | PORTION |
|---|---|---|
| Bourbon | 85 | 1 brandy glass |
| Champagne | 85 | 1 wine glass |
| Egg Nog | 300 | 1 wine glass |
| Gin, dry | 75 | 1 brandy glass |
| Muscatelle wine | 164 | 1 wine glass |
| Port wine | 164 | 1 wine glass |
| Rum | 75 | 1 brandy glass |
| Rye | 85 | 1 brandy glass |
| Scotch | 75 | 1 brandy glass |
| Sauterne | 80 | 1 wine glass |
| Sherry wine | 137 | 1 wine glass |
| Sloe gin | 225 | 1 wine glass |
| Vermouth | 175 | 1 wine glass |
| **DESSERT** | | |
| Apple pie | 365 | 1 serv. |
| Cocoanut pie | 475 | 1 serv. |
| Lemon Meringue pie | 450 | 1 serv. |
| Pumpkin pie | 365 | 1 serv. |
| Raisin pie | 450 | 1 serv. |
| Fruit cake | 245 | 1 sl. |
| Macaroons | 58 | 1 |
| Sponge cake | 164 | 1 2" square |
| Plum pudding | 442 | 1 piece |
| Chocolate cream candy | 110 | 1 |
| Chocolate milk bar | 500 | 1 bar |
| Date, stuffed | 35 | 1 |
| Marshmallows | 15 | 1 |
| Mints, after dinner | 12 | 1 |
| Mints, chocolate | 34 | 1 |
| Chocolate syrup | 42 | 1 Tablesp. |
| Maple syrup | 70 | 1 Tablesp. |
| Apple sauce | 122 | ½ cup |
| **NUTS** | | |
| Almonds | 7 | 1 |
| Brazil | 7 | 1 |
| Cashew | 7 | 1 |
| Cocoanut, fresh | 25 | 2½" sq. |
| Hazelnuts (filberts) | 7 | 1 |
| Pecans | 28 | 1 |
| Pistachios | 3 | 1 |
| Walnuts, California, black | 40 | 1 |
| **MISCELLANEOUS** | | |
| Bread, rye | 65 | 1 sl. |
| Bread, white | 65 | 1 sl. |
| Bread, whole wheat | 65 | 1 sl. |
| Rolls, plain | 165 | 1 |
| Rolls, water | 115 | 1 |
| Crackers, graham | 35 | 1 large |
| Crackers, soda | 31 | 1 |
| Sugar, brown | 35 | 1 Tablesp. |
| Sugar, granulated | 20 | 1 teasp. |
| Sugar, crystal squares, Domino | 12 | 1 |
| Crisco | 110 | 1 Tablesp. |
| Mazola oil | 135 | 1 Tablesp. |
| Wesson oil | 95 | 1 Tablesp. |
| Chicken fat, rendered | 140 | 1 Tablesp. |
| Chili sauce | 39 | 1 Tablesp. |
| Horseradish | 5 | 1 teasp. |
| Ketchup | 6 | 1 Tablesp. |
| Mustard, com. | 27 | 1 Tablesp. |
| Olive, green | 16 | 1 |
| Olive, ripe | 11 | 1 |
| Pickle, dill | 8 | 1 med. |

## WITH NEW JERSEY MEDICAL AUTHORS

Compiled by MILDRED V. NAYLOR, Librarian, Academy of Medicine

It is requested that any New Jersey physician who publishes an article outside the state, notify the Editorial Office in Trenton, giving the title of the paper and the name of the periodical, as well as the month, date, volume and page number. It would also be helpful to this office if members would notify us of articles published by their colleagues.

ALLOWAY, HON. JOSEPH E.—Trenton

Board of Childrens' Guardians health program. J. Med. Soc. New Jersey 42: 326-27, Oct. 1945

APPLEBAUM, IRVING I.—Newark

1. Complications of staphylococcus sepsis; treatment by intrapleural and intrapericardian injections of sulfa compounds. Mil. Surgeon 96: 424-429, May 1945
2. Lymphocytosis in the cerebrospinal fluid. Ann. Int. Med. 23: 170-176, Aug. 1945

BEGNER, JACOB A.—see Woodruff, Stanley R.

BROWN, CHESTER W., M.D.; LESLIE A. MCCLINTOCK, M.S., and EDWARD R. NEARY, M.D.—Newark (White Laboratories)

Established surgical infections; treatment with

urea-sulfanilamide mixture. Am. J. Surg. 70: 4-12, Oct. 1945

Butler, E. G., Ph.D.—see Harvey, E. Newton

Clement, Baxter L.—Newark (in service)
Fractures of the head of the radius. J. Med. Soc. New Jersey 42: 317-19, Oct. 1945

Federer, John J.—Weehawken (in service)
Glycosuria and hyperglycemia associated with acute meningitis; report of a case. New England J. Med. 233: 342-43, Sep. 20, 1945

Goldstein, Hyman I.—Camden
Discovery of the roentgen rays. William Konrad Roentgen, March 27, 1845-February 10, 1923. Rev. Gastroenterol. 12: 201-08, May-June, 1945

Harvey, E. Newton, Ph.D.; E. G. Butler, Ph.D., W. O. Puckett, Ph.D., and J. H. McMillan, Ph.D. —Princeton
Mechanism of wounding. War Med. 8: 91-104, Aug. 1945

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Nutrition in everyday practice. J. Med. Soc. New Jersey 42: 306, Sep. 1945; 332, Oct. 1945

Kern, E. Clarence—Montclair
Local reaction to penicillin given by mouth. J. Med. Soc. New Jersey 42: 326, Oct. 1945

Leach, John J.—Paterson (in service)
Diseases and defects in aircrew trainers. War Med. 8: 5-8, July 1945

Leonard, Martha F.—Highland Park
Hemolytic disease of the newborn (erythroblastosis fetalis); clinical analysis of 55 cases, with special reference to pathogenesis, prognosis and therapy. J. Pediat. 27: 249-65, Sep. 1945

Little, Ernest—Dean, College of Pharmacy, Rutgers University, Newark
Commencement address. New Jersey J. Pharm. 18: 4-7, Sep. 1945

McClintock, Leslie A.—see Brown, Chester W.

McMillan, J. H., Ph.D.—see Harvey, E. Newton

Neary, Edward R.—see Brown, Chester W.

Parsonnet, Eugene V.—Newark (in service)
Periosteum for herniotomy, procedure used for direct and femoral hernias. J. Med. Soc. New Jersey 42: 304, Sep. 1945. (Reprinted from Mod. Med. 13: 81.)

Puckett, W.O., Ph.D.—see Harvey, E. Newton

Read, Hilton S.—Atlantic City (in service)
Acute psychosis following therapeutic malaria in a case of neurosyphilis. J. Ner. & Ment. Dis., Sep. 1945

Read, Hilton S.—Atlantic City (in service)—with Abraham I. Friedman
Orthostatic (lordotic) albuminuria, including studies on patients in hyperetension body casts. New York State J. Med. 45: 2075-2078, Oct. 1, 1945.

Rice, Franklin W.—Morristown
Appendicitis. J. Med. Soc. New Jersey 42: 294-98, Sep. 1945

Scott, Norman M.—Newark
Medical program that reaches all. Hospitals 19: 64-65, Sep. 1945

Taylor, John H.—Trenton
Shock therapy, 1937-1944. J. Med. Soc. New Jersey 42: 300-04 Sep. 1945

Waters, Edward G.—Jersey City
Use of fine chromic catgut for postpartum perineal repair. Am. J. Obst. & Gynec. 50: 319-325, Sep. 1945

Woodruff, Stanley R., and Jacob A. Begner—Bayonne
Sacrococcygeal teratoma in an infant of five months causing acute urinary obstruction. J. Urol. 54: 177-181, Aug. 1945

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## HOSPITAL PERSONNEL NEEDED IN CHINA

The Chinese Government has requested UNRRA to provide, as soon as possible, some 200 field personnel of the following categories to strengthen the available Chinese personnel. Such personnel will be required to head the respective services in hospitals of 100 or 250 beds, which will be established in areas recently liberated from the Japanese.

General Surgeons
Orthopedic Surgeons
Genito-Urinary Surgeons
Gynecologists and Obstetricians
General Physicians
Dermatologists and Syphilologists
Ophthalmologists
Otolaryngologists
Radiologists
Dentists
Pediatricians
Laboratory Technicians
X-Ray Technicians
Sanitary Engineers
Public Health Engineers
Public Health Nurses
Clinical Nurses

General practitioners with some specialist experience will be acceptable. Candidates should be under 55 years of age and in good physical condition.

Physicians interested should write to Szeming Sze, M.D., Chief, Far East Section, Health Division, UNRRA, 1344 Connecticut Avenue, N. W., Washington 25, D. C.

## INTERNATIONAL COLLEGE OF SURGEONS CONVENTION

The International College of Surgeons will hold its Tenth Annual Convention and Convocation on December 7 and 8, 1945, at the Mayflower Hotel, Washington, D. C. At this time approximately 200 men will receive their Fellowship. A scientific program is planned for both days. Convocation exercises will be held on December 7th in the auditorium.

## OBITUARIES

### DR. FRANK A. BIEN

Dr. Frank A. Bien, former state assemblyman, died on October 19, 1945, at St. Luke's Hospital, New York, after an illness of three months.

Born in Newark in 1890, Dr. Bien attended grade schools there and was graduated from St. Benedict's Preparatory School. He was also a graduate of Rutgers University School of Pharmacy and New York Medical College. He was serving his internship at Metropolitan Hospital, New York, when we entered World War I and served throughout the war as a captain in the Medical Corps overseas.

After the war Dr. Bien studied for a time in Europe and then went to Irvington where he lived and practiced medicine.

During World War II Dr. Bien was in charge of the medical division of Irvington Defense Council. He was a member of the staffs of Irvington General Hospital, East Orange General Hospital, St. Michael's Hospital and Presbyterian Hospital in Newark. He was also a member of the Essex County Medical Society, The Medical Society of New Jersey, American Medical Association, the Academy of Medicine of Northern New Jersey, American College of Surgeons, the Anatomical and Pathological Society and the Physician's Club.

### DR. MORTIMER S. FAULKNER

Dr. Mortimer S. Faulkner, Orange physician and member of the staff of Orange Memorial Hospital, died at the hospital on August 8, 1945.

Dr. Faulkner was born in Ninekah, Okla., in 1914. and received his M.D. degree at the University of Oklahoma. He interned at Orange Memorial in 1942 and had been associated with the institution since.

Dr. Faulkner was a member of the Essex County Medical Society, The Medical Society of New Jersey and American Medical Association.

### DR. WILLIAM E. RINK

Dr. William E. Rink, widely known Burlington physician, died at his home on September 26, after a two months' illness.

Dr. Rink, who was 64, had practiced in Burlington for 35 years, succeeding his father, Dr. Eugene Rink. He was graduated in 1903 from the Hahnemann Medical College, the youngest member of his class, and served his internship at a Brooklyn hospital.

He was a captain in the Army Medical Corps in the First World War and served overseas for nine months. He was a member of the Burlington City Board of Health, the Burlington County Medical Society, The Medical Society of New Jersey and American Medical Association.

### DR. STANLEY R. WOODRUFF

Dr. Stanley R .Woodruff, urologist and a former president of the Bayonne Board of Education, died at his home in Bayonne on October 13, 1945, following a long illness.

Born in Orange, Conn., in 1875, he attended elementary schools there and studied pharmacy at Brooklyn College of Pharmacy, from which he was graduated in 1895. He then entered the College of Medicine of Yale University and two years later was awarded his medical degree. After interning at Bridgeport Hospital, Bridgeport, Conn., Dr. Woodruff came to Bayonne to practice medicine.

He became clinical professor of urology at the Post-Graduate Hospital and New York Polyclinic Hospital in New York, as well as consulting urologist at St. Mary's Hospital, Hoboken, Hackensack Hospital, Middletown Hospital in Middletown, N. Y., and St. Vincent's Hospital, Staten Island. He was attending urologist at Bayonne Hospital and Christ Hospital, Jersey City.

Dr. Woodruff was the author of "Urographic Urology" and numerous papers and treatises on urology. He collaborated with the late Frederick Wappler in devising the Woodruff Catheter and cystoscopic stand.

He became a recognized authority on urology and was consulted by numerous other specialists in that field. His contributions in medical practice and research won him election as a fellow of the American College of Surgeons and a diplomate of the American Board of Urology. Further honors included election as an honorary member of the Societa Italiana Di Urologia, as well as member of the New York Academy of Medicine, serving as president of the Urological Section. He was a member of the Society of Surgeons of New Jersey, the American Urological Association and a past president of the New York section, the New Jersey, Hudson County, Bayonne and national medical societies, and chairman of the Practitioners Club of Jersey City.

# COUNTY SOCIETY REPORTS

## ATLANTIC COUNTY

Walter B. Stewart, M.D., Reporter

The first meeting of the *Atlantic County Medical Society* for the year 1945-46 was held in the Chelsea Hotel on Friday, September 14, 1945. The guest speaker of the evening was WILLIAM BATES, M.D., President of the Medical Society of the State of Pennsylvania, and Professor of Surgery at the Graduate School of Medicine, University of Pennsylvania. His subject was "Parietal Neuralgia Simulating Visceral Disease".

Parietal or segmental neuralgia may occur in any part of the body and when present may be interpreted as disease of the underlying viscera. Many cases of pain occur in which the clinical symptoms are out of all proportion to the extent of the pathological lesion. For instance, removal of the appendix may not relieve the abdominal pain, which can be a parietal or segmental neura'gia. The unpardonable sin is to permit 26 abdominal scars, yet still find the pain persisting. Never cut the belly without first examining the spine. In others there were hip disease, tuberculosis of the spine, and pneumonia. We all recognize the referred pain in the shoulder and the arm in cases of heart disease. The pain of subdeltoid bursitis originates in the supraspinatus muscle, and is a superficial neuralgia.

Dr. Bates then described methods of differentiating parietal and visceral pain. An exact knowledge of the distribution of sensory nerves in the skin is essential. Blocking off the sensory nerves by injection of novocaine in the paravertebral area is an important differential method. It relieves the pain but does not influence the tenderness of an inflamed appendix. As an aid to diagnosis, Dr. Bates would rather have a syringeful of novocaine than a blood count. This method prevents much unnecessary surgery. In cases of referred pain, the skin is not sensitive or tender. Pinch it to find out. When the pathologist reports that the appendix was normal, watch for the same old pain to recur but look for other causes. These may be found in infection of the sinuses, the tonsils, or the teeth; also in trauma, postural defect, or disease of the vertebra, such as chronic infection or malignancy. The driver of an auto sitting for hours in a pinched position may develop gallbladder symptoms. Poor posture is a frequent source of parietal neuralgia. The scoliosis with one low shoulder caused by a short leg can be overcome by building up the heel of the shoe on one side, or in a woman by subtracting from the heel of the shoe on the other side. Later, any lordosis that may be present can be adjusted. The Goldthwait exercises to improve posture are based on the theory that pains are caused by congestion of the visceral organs. Posture may be improved by pushing up the head, pulling in the abdomen, and tensing the buttocks.

Dr. Bates has done considerable research on the use of sarapin, an extract of the root of the Pitcher Plant, and ammonium chloride or sulfate, for the injection of nerves to obtain relief from pain, and has found them superior to other anesthetics. Sarapin has a selective action on the pain fibers of the peripheral nervous system. Morphine may give no relief in metastatic carcinoma, yet sarapin may quiet the patient promptly. In 80 per cent of cases, abdominal pain lasting over three months has its origin in the parietes rather than in the viscera. When doubt exists between visceral and parietal origin of pain, the patient should receive the benefit of doubt, and the viscera should be examined.

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The October meeting was held in the Chelsea Hotel on October 12, 1945, at 9:00 p. m.

The guest speaker of the evening was DR. SAMUEL ALEXANDER, President of The Medical Society of New Jersey. His subject was,

"1. Some of the Problems of The Medical Society of New Jersey.
2. Care of the Chronic Ill."

Although these are difficult times for the doctors in organized medicine, yet they do find time to attend meetings of their component societies, and committees of which they are members. Dr. Alexander considers remarkable the attendance record at meetings such as those of the Welfare Committee. In the work of any committee it is best to tackle only two or three problems each year, but to follow through and get that work done.

The Public Relations program is the biggest thing in organized medicine today, selling the doctor to the public and thus obtaining public support. In the past we have taken too much for granted. A program that is properly sponsored and paid for is necessary with a full-time set-up. Dr. Norman Scott will temporarily assume this responsibility in our State Society, relieving Mrs. Madden. We must get a permanent Executive Officer to fill the vacancy created by the death of Dr. LeRoy Wilkes.

The Cancer Control Committee has been aided by the national drive for funds. This state will receive $100,000 as its share of the total, for the allocation of which the Committee is seeking concrete recommendations.

The Intern Training Committee advises that every hospital should have a well coördinated program for its interns. The Post-Graduate Education Committee is working out a program of post-graduate training for the general practitioner through Rutgers University, which should be ready before the end of the year. Much of the training will be made available through the medical schools of Philadelphia and New York, and will be open to physicians returning from the armed forces. The veterans should receive the same hospital advancement as those men who were not in the service;

and some will need financial aid, for which each County Society should appoint a committee.

The Legislative Committee has a key-man in each county, holding a position of great importance. Dr. Alexander gave high praise to our key-man, Dr. Allman. The state legislature has the power to say whether or not the doctor can continue to practice medicine. Special groups are always at work trying to get through new and often harmful acts, against which the key-man must be ever vigilant. E. M. I. C. has not been objectionable as a war measure, but now attempts are being made to have it as a permanent program. It seems at present that the Wagner-Murray-Dingell Bill can not be passed as a whole, but attempts will probably be made to split it up and introduce one part at a time, which measures must be blocked at the start. Most legislators are sympathetic and willing to help, if they are properly approached and informed.

The most pressing problem is how to take care of the returning veteran, which must be solved at once. The Connecticut State Medical Society has a Veterans Advisory Board which meets with the Veterans Bureau, forming a smooth-working liaison.

Another big problem today is what to do with the chronic ill, since people live longer and geriatrics comes more to the fore. These are the cases of heart disease, the arteriosclerotic, the rheumatic, the diabetic, and the postpoliomyelitis. Then there is the economic problem of the ill wage-earner. Twenty per cent of the beds in the hospitals of New York City are filled by the chronic ill, most of them among the poor rather than among the rich, and most of them amenable to help. Government must aid in the solution of this problem, not the federal and not the municipal, but rather the county government. All of the chronic ill should be sent to a board of doctors, set up by the county, for diagnosis and for determination of what, if anything, can be done for them. Hopeless cases can be sent to a welfare home or a private nursing or boarding home. For the indigent, the county pays the bill or the family receives a grant from the welfare board. The best plan is to have a committee from the County Society go to the county governing body with a positive, constructive program; and almost certainly assistance will be obtained. In Bergen County there are three hospitals available for these cases. In the care of the aged, remember not to keep them in bed too long and to use the sulfa drugs freely in the prevention of pneumonia. Don't lose hope even in inoperable carcinoma, for some cases can have their lives prolonged for years. We can not escape our responsibility in the care of the chronic ill.

## BURLINGTON COUNTY

T. B. Dickson, M.D., Reporter

The first meeting of the *Burlington County Medical Society* for the year 1945-46 was held on September 13, 1945, at the Burlington County Hospital. DR. WILLIAM E. BRAY, President-Elect, presided.

DR. JOHN H. BLAND spoke on the Guillain-Barre Syndrome, with a report of four cases from the Burlington County Hospital. The topic was a new one to the members and as a result was very interesting and educational.

DR. PERRY MACNEAL discussed the subject and gave the points of differential diagnosis between the Guillain-Barre Syndrome and poliomyelitis and meningitis.

It was announced that CAPTAIN DEAN LE FAVOR is a patient in Tilton Hospital at Fort Dix.

It has been suggested that an attendance law be added to the By-Laws of the County Society. This law would state that if a member be absent from two consecutive meetings without a bona fide excuse, he be dropped from the County Society.

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A regular meeting of the Society was held at the Riverton Country Club on October 11, 1945.

DR. PAUL MECRAY, JR., of Camden, spoke on his medical and surgical experiences in the China-Burma-India Theater. He spoke of diseases which are only names to a great many physicians, such as tsutsugamushi fever, amoebiasis, favus and schistosomiasis. Dr. Mecray described in detail the treatment of wounds which the soldiers received in combat. At the end of his talk, Dr. Mecray was kept busy answering questions.

It is with sorrow that the County Society announces the death of DR. WILLIAM E. RINK of Burlington.

It was decided that the afternoon meetings would be discontinued and the Society hereafter will hold meetings in the evening.

The Society accepts with regret the resignation of DR. HARRY L. ROGERS.

DR. ARTHUR B. PEACOCK resigned from his post as Secretary of the County Society. DR. HOWARD C. CURTIS was appointed to fill the vacancy.

## CAMDEN COUNTY

Joseph C. Lovett, M.D., Reporter

The *Camden County Medical Society* held its first fall meeting October 2, 1945, at the Camden City Dispensary with DR. HENRY B. DECKER, President, presiding. There were forty members present.

The speaker of the evening was DR. JOHN B. MONTGOMERY, Clinical Professor of Gynecology of Jefferson Medical College, who gave an interesting talk on "Management of the Menopause Patient". Some of the things brought out in his talk were that the management of these patients really belongs in the category of the general practitioner This is an epoch in the life of a woman which characterizes many changes and must be viewed in a broad sense. Menopausal changes take place long after the ovaries fail to function and the menses cease. The average age for the stoppage of menses is forty-seven years. A woman that menstruates beyond fifty-five years of age should be examined for possible trouble.

There are profound changes in the physiological structures. Sometimes the change brings a marked improvement in health. The etiology is the endocrine change. This is due to the normal aging of the ovary. Failure of ovulation is due to the ovary becoming refractory to the stimulation of the pitui-

tary. There is often an excessive stimulation from the follicle stimulating hormone of the pituitary. The excess of gonadotropine in the blood causes the menopausal symptoms. In the course of time, these subside.

Symptoms of menopause are nervous and emotional symptoms, acute awareness of advancing age, many fears as of cancer and other diseases and economic security. The over-action of the sympathetic nervous system causes an over-anxious state. The withdrawal of hormones cannot cause a true organic disease. Physical changes take place such as gain in weight and later the regressive changes. The great majority of normal women pass through this period without any symptoms. With our increasing knowledge of hormones, more women are coming to the doctors. Only 10 per cent have actual severe menopausal symptoms. Circulatory symptoms are prominent, such as hot flushes, etc., depression and changes in the joints, especially the knees. All these symptoms should be investigated before saying they are just due to the menopause as there may be organic disease present.

Treatment must be considered from a broad medical standpoint. The symptoms are due to normal physiological changes. Carefully explain to the patient what the menopause is. This goes far toward allaying the symptoms. General sedation is the best drug therapy. Endocrine therapy is accepted purely as a substitution therapy. Contraindications for endocrine therapy are cancer, radiation menopause, radiation for benign bleeding. Prolonged use of estrogens in a patient where there is no improvement should be stopped. Use good full doses to control the symptoms quickly and then step down the dosage. Give the treatment in cycles.

In discussion of the paper, Dr. Thomas B. Lee said it is important that the family physician take care of these patients. Many patients have the most pleasant and most comfortable life after the menopause.

Dr. H. P. Shipps: The potency of these endocrines should be emphasized. It is a mistake to give estrogens to patients with excess of menstruation.

Dr. I. E. Deibert: A woman with a breast tumor should not have any estrogenic substance. It may hasten a benign tumor into a malignant one.

Dr. J. B. Montgomery: Testosterone is justifiable where proven it is a functional bleeding. Radium is the best way to treat this functional bleeding. A patient with a breast tumor should not get estrogens.

The business meeting followed. The application for membership of Dr. Leslie R. Angus was approved.

Reports of committees followed. Dr. Bentley said the screening business of x-ray should be handled through the Camden County Tuberculosis Association. A committee is to be appointed to assist Dr. Collier. Dr. Collier stated that screening means mass x-rays for tuberculosis. This is done for the school children with a 70-mm. x-ray to take the films. The report on what is found is sent to the family physician.

Dr. Shipman stated that to keep our insurance up to 60 per cent, all new members and those returning from services should get proper applications for this insurance.

The two members present who have just returned from service were Col. Leslie Wilson and Lt. Col. T. V. McDermott.

At the June annual outing at Tavistock, five members of the Society were given diplomas for fifty years of practice. They were Dr. Paul M. Mecray, Dr. William H. Pratt, Dr. Grafton E. Day, Dr. Lavinia B. Clement and Dr. Lee E. Griscom.

## CAPE MAY COUNTY

C. W. Way, M.D., Reporter

A regular dinner meeting of the *Cape May County Medical Society* was held at Fred's Restaurant, Cape May Court House, at 9:00 p.m. on October 9, 1945.

The guest speaker was S. Eugene Dalton, M.D., F.A.C.S., of Atlantic City. His subject was "Kodachrome Cinematography of the Epipharynx". The film was presented to stimulate interest and add to our knowledge of the epipharynx. It was potentially divided into four parts. The first showed the method for studying the nasopharynx; the second, its anatomy, with special attention to the epipharyngeal pouches; the third, a series of malignant tumors and two unusual cases of Thornwaldt's disease; the fourth part portrayed visually the experimental work on determining the etiology and treatment of hypertrophied lymphoid tissue of the epipharynx. The conclusions were made after six years of careful observation by Dr. Dalton. He stated that the epipharynx was once called "No Man's Land" and he hoped the picture will change that caption to "The Beachhead" for invasion of the human body by bacteria and bacterial products. Also it is an area not infrequently invaded by tumors, benign and malignant.

Last but not least, the overgrowth of lymphoid tissue that obstructs the nasopharynx blocks the eustachian tubes and produces other pathological changes in the body. There are four epipharyngeal pouches located below each inferior turbinate and a triangle of three midway between these two points. They act as an incubator and an absorptive area for infections. The eustachian tube orifice was seen on the lateral wall. Its anterior lip contains the free extremity of the cartilaginous tube, causing a projection known as torus tubarius. At the lower margin lies the salpingopharyngeal fold. Above and below the torus tubarius could be seen the fossa of Rosenmuller.

We then saw beautiful colored pictures of Thornwaldt's disease, squamous cell carcinoma, lymphosarcoma, squamous cell epithelioma, transitorial cell carcinoma of the nasopharynx, carcinoma of the epipharynx.

Dr. Dalton discussed hypertrophied lymphoid tissue of the epipharynx and its etiology and treatment. He stated that dysfunction of the thyroid gland produces hyperplasia of lymphoid tissue and lowers resistance to infection. Subsequently chronic paranasal sinus infection and lymphoid hypertrophy

frequently produces obstruction of the epipharynx, blocking of the eustachian tubes and their effect on hearing and the nervous system. He showed two very interesting cases of obstruction with hypothyroidism and suppurative sinusitis. It was a very scientific and educational film.

The pictures and lectures were discussed by DRS. HORNBERGER, CROWE, DILLENBERG and FISH.

The Society was honored by the presence of the State Society's Second Vice-President, Dr. J. Howard Hornberger of Roebling; Mrs. Hornberger, Mrs. William E. Dodd of Beach Haven, Mrs. David Allman of Atlantic City, Dr. Eleanor E. Beesley of Brooklyn, N. Y.; Dr. Joseph Dillenberg of New York City, Major Markowitz of the U. S. Army Medical Corps, Dr. Clyde Fish of Pleasantville, N. J., and twenty graduate nurses who reside in Cape May County.

The regular November meeting of the Society will be held at the Atlantic Shores Hospital, Somers Point, N. J., on Tuesday night, November 13, 1945, at 9:00 p.m.

## CUMBERLAND COUNTY

Norman W. Henry, M.D., Reporter

The first Fall meeting of the *Cumberland County Medical Society* was held October 9, 1945, at the Circle Restaurant, Vineland. Twenty-eight members and one guest were in attendance.

The meeting was called to order by the President, DR. GEORGE N. THOMAS.

DR. M. A. PESTORE of Vineland was elected to membership of this society.

MR. A. J. TAYLOR, recently appointed Superintendent of the Newcomb Hospital, was introduced by the President. He extended his full coöperation to the medical profession and brought up the subject of Syphilis Therapy with Penicillin. Hospitalization in these cases of early syphilis requires seven days of treatment, and he extended the privileges of hospitalization for such care. He also announced that the hospital will soon have the advantage of Pneumothorax Therapy.

Dr. Walker and Dr. Kump reported on the Welfare Meeting held at Trenton. Subjects included the Wagner-Murray-Dingell Bill and the care of the returning veterans. No definite decision was reached, but a committee was appointed to look after this matter in regards to our own society.

Dr. Thalheimer of Vineland, a member of the Insurance Committee, reëmphasized that all new members and returning veterans are eligible for the medical insurance plan instituted in this society one year ago.

Dr. Kump introduced DR. HENRY DECKER, a member of the teaching staff of the Jefferson Hospital, Philadelphia, and dermatologist at the Cooper Hospital, Camden, who presented an interesting discussion on various skin diseases.

Dinner was served following adjournment.

## ESSEX COUNTY

Anthony Ambrose, M.D., Reporter

The Essex County Medical Society Council met on Tuesday, September 25, 1945.

The Council voted $250 to be given to the Woman's Auxiliary to help the organization continue with its work.

The Committee on Medical-Legal Testimony was empowered to arrange a meeting with several judges of the Federal and County Courts, the Commissioner and Deputy Commissioner, and the Chief Referee of the Workmen's Compensation Court; also to purchase copies of court testimony of any case if needed.

Request has been made to the State Society asking that a committee be appointed to review the Workmen's Compensation Act of 1934-35.

The matter of examining Veterans for the Veterans' Bureau was referred to the Welfare Committee of the State Society.

The Council went on record as having the County Society willing to coöperate in setting up a bureau to assist in the adjudication of veterans' claims.

The President of the County Society has gone ahead with plans for the establishment of a central blood bank in Essex County.

MORRIS FISHBEIN
ESSEX COUNTY MEDICAL SOCIETY
91 LINCOLN PARK, NEWARK, N. J.

The meeting on Wednesday, December 12, 1945, will be addressed by Dr. Morris Fishbein, Editor of the J. A. M. A. and member of many committees and councils. The topic will be "Medicine in the Postwar World". The brilliant speaker will discuss the entire legislative condition in relation to changes in medical affairs.

This will be a combined meeting with the Academy of Medicine of Northern New Jersey. Note change of date for both societies.

## GLOUCESTER COUNTY

A. Guy Campo, M.D., Reporter

The *Gloucester County Medical Society* met at Maier's, in Woodbury, on September 20, 1945. DR. I. N. PATTERSON, President, stated that the second meeting (October) will be the social session for the year. A committee of three was appointed to determine the place to hold the dinner and entertainment.

The guest speaker of the evening was DR. H. F. FLIPPIN, Associate Professor of Medicine at the University of Pennsylvania. His subject was "Chemo-Therapy". His remarks covered from ancient to modern chemo-therapy. With the advent of science and research the following startling discoveries were made:

1850—The coal industries were responsible for aniline dyes and carbolic acid.

1860—The wine industry, under Pasteur, led to famous fermentation experiments.
Under Koch the aniline dyes were a subject of experimental research.

1874—Lord Lister, in his work with carbolic acid, decided that infection was caused by bacteria, and that carbolic acid had the property of destroying bacteria.
About this same time Ehrlich spoke of the "elixers of life".

1900—Anilin and sulphuric acid were combined to form tripan red.

1906—Anilin and arsenic combined to form the famous "606".

1908—The dye industry under the leadership of Gelmo, found sulphonamides.

1929—Fleming brought forth penicillium.

1932—Domagk discovered prontosil.

1935—We have sulfanilamide.

1938—Sulfapyridine.

1939—Sulfathiazole.

1941—Sulfadiazine.

1943—Sulfamerazine.

1945—Streptomycin.

PENICILLIN

Penicillin is rapidly eliminated when given intravenously. When given intramuscularly, it has a longer reaction. The best dosage is 20,000 units. Larger doses do not give a much higher blood level. The daily dosage of penicillin varies from 100,000 units to 300,000 units. Factors involved are as follows: (1) Age and weight of individual. (2) Whether disease is acute or chronic. (3) Type of infection.

Administration of penicillin: (1) Oral. Penicillin is destroyed by hydrochloric acid. Although when given in ten times the dose you get results. (2) Rectal. Penicillin is destroyed by penicillinase. (3) Intravenously. Rapid elimination of penicillin when given intravenously does limit its use. (4) Intramuscularly is the best method.

Intravenous route: (1) Continuous infusion. (2) Large needle. (3) Elevation of extremity. (4) Alternating salt and glucose solution. (5) Changing apparatus daily. (6) Rate 33 to 36 drops per minute. (7) Number of drops minus five, multiplied by one hundred will give you the twenty-four-hour total.

Intramuscular route: (1) At least eight injections daily. (2) Use concentrated solution. (3) Rotate injections in various muscles. (4) Alternating diluents. (5) Add 0.5 per cent procaine solution to remove pain. Label same because if given intravenously may cause death.

Local route: A. Topical applications. (1) Powder—50 to 5,000 units per gram of powder mixed with sulfonamides. (2) Solution—250 to 500 units per c.c. (3) Ointments—250 units per gram.

B. Local injections may be given into the spinal, pleural, peritoneal and synoveal fluids.

Penicillin sensitivity does occur, as in sulfonamides, therefore treat with large amounts, rather than cause sensitivity. Penicillin is being used in bacterial endocarditis and twelve of twenty cases are living after one year of penicillin therapy.

Penicillin therapy: Advantages: (1) Activity is not influenced by pus. (2) Activity only slightly influenced by bacteria. (3) More efficient with certain bacteria. (4) Essentially non-toxic. Disadvantages: (1) Is ineffective with gram negative bacteria. (2) Administration. (3) Availability. (4) Cost.

STREPTOMYCIN

Streptomycin is like penicillin in that you have rapid elimination from the kidneys. Streptomycin is not influenced by hydrochloric acid. It has no action on kidney or liver function. It is specific in tularemia, pyocyanus and brucellus. You do get some results in Rocky Mountain spotted fever, para-typhoid carriers, ulcerative colitis. At present there is no definite evidence of streptomycin's effect on typhoid fever. It does not cure, but decreases its toxicity.

Streptomycin, at present, costs twenty dollars per million units. The average daily dosage at present, is four million units. Although there is a small amount of streptomycin available, the cost is prohibitive.

## HUDSON COUNTY

Harry J. Perlberg, M.D., Reporter

A regular meeting of the *Hudson County Medical Society*, the first of the official year of 1945-46, was held on October 2, 1945, at the Masonic Club in Jersey City. It was called to order by the President, DR. HUGH H. TYNDALL.

Election of New Members: DRS. LOUIS HUSS, Union City; ALLAN A. KLEIN, North Bergen; HENRY TERWEDOW, North Bergen; HENRY A. VITI, Jersey City; DAVID GOLDMAN, Bayonne, and ELEANOR GRISSEY, Jersey City.

Passed by Board of Censors for Reinstatement: DR. CONCETTA G. MANGO of North Bergen.

DR. ROY B. HENLINE, Attending Urologist, James Buchanan Brady Foundation of the New York Hospital, spoke on "Prostatic Disease".

In view of the prevailing belief that all prostatic disease develops in the same area and from the same portions of the gland, Dr. Henline said he wished to state emphatically that there are *three* general areas within the prostate which may be involved in a pathological process, and *three* main types of prostatic disease; namely, prostatic infections, prostatic hyperplasia, and carcinoma of the prostate. It is usual for each type of pathology to confine itself, at least during its inception, to a particular area. It should be realized, however, that any combination of these three distinct entities may coexist.

*Prostatic Infections.* Frequently observed in the midd'e-aged and older, this type of pathology occurs in the two lateral lobes, usually referred to as the functioning prostatic glands. Bacteria may invade the deep recesses of these tortuous glands in the lateral lobes and produce an acute or chronic prostatitis or a prostatic abscess, or they may be the seat of endogenous prostatic calculi. According to recent investigation, the speaker said, the functioning portions of these lateral lobes are rarely the site of origin of either prostatic hyperplasia or carcinoma.

Chronic prostatic infections are of common occurrence, and by far the greater percentage of

cases is not caused by gonorrhea. Infection in the prostate occurs more frequently from some nonspecific infection in the urinary tract or from a distant focus of infection, such as the teeth, tonsils, intestinal tract, respiratory tract, and furuncles.

*Prostatic Hyperplasia.* It is generally agreed that hyperplasia of the prostate, also referred to as adenoma and enlargement of the prostate, usually develops just beneath the urethra, from which the growth extends to compress the functioning glands of the lateral lobes toward the capsule, and hence assumes the position of the lateral lobes on each side of the urethra. It may also develop in the median, subcervical, or subtrigonal lobe, where nests of glands are present. It does not occur in the posterior lobe of the prostate, nor does it originate in the functioning glands of the lateral or median prostatic lobes.

*Carcinoma of the Prostate.* This lesion, shown by statistics to develop in approximately 15 per cent of men past fifty years of age, usually develops in the posterior lobe of the prostate, an area rarely, if ever, affected by either infection or hyperplasia, but it may arise in other portions of the gland. It should be kept in mind, however, that carcinoma and hyperplasia, even when found in the same portion of the gland, are two distinct lesions that develop independently of each other.

Unlike most other disturbances in this gland, early uncomplicated carcinoma of the prostate gives no symptoms. Detection of its presence devolves upon the physician making periodic health examinations, without whose assistance few cases of uncomplicated early malignancy reach the urologist.

In a rectal examination of the prostate, the posterior lamella (where 75 per cent of carcinoma develops) is contacted with ease. Early carcinoma may be suspected by palpation of a hard nodule near the presenting surface of the prostate. Diagnosis is preferably made by biopsy and frozen section taken through a perineal exposure of the prostate. It was emphasized that while palpation of the prostate by rectum is a most valuable diagnostic aid, particularly in detecting *early* malignancy, the physician who relies on this method alone will be frequently entirely misled.

In determining the presence of extensive carcinoma of the prostate, a recent finding forms the basis of a useful method of diagnosis—namely, that an enzyme, acid phosphatase, although normally present in the blood serum, increases in quantity when carcinoma metastasizes to the bone, and the rapidity of the growth of the malignancy can be quantitatively estimated by the amount of serum acid phosphatase in the blood. This elevation occurs only in carcinoma of the prostate.

(Dr. Henline here showed a series of slides illustrating the three types of prostatic lesion.)

*Treatment.* Where surgery is indicated, the speaker asserted, it is only when one has the most complete knowledge possible of the origin and mode of progression in a case of prostatic infection, hyperplasia or carcinoma, that he can select the proper surgical procedure. The method employed in each instance should be the one which will adequately remove the obstruction, cause minimum shock to the patient, and interfere least with the normal tissue in approximation to the obstruction, and therefore leave the patient with the best functional result.

Radical total perineal prostatectomy is undoubtedly the surgical treatment of choice in early carcinoma of the prostate, the term *early* implying that it is still entirely confined within the boundaries of the organ. It is important to keep in mind that while carcinoma of the prostate exhibits early invasion of the perineural lymphatics *within the organ,* metastases and invasion *outside the organ* is a late manifestation of the disease.

In advanced carcinoma of the prostate—the term *advanced* indicating that the lesion has spread beyond the confines of the prostatic capsule—when lower back pain together with distress associated with urination is present, complete surgical removal of the prostate is not to be considered, but other methods of treatment may be undertaken.

Recent studies indicate that the stimulus causing the dissemination of prostatic carcinoma may be an imbalance between the male and female sex hormones, possibly brought about by an alteration in the quantity in which these two elements are produced within the body at about the age of fifty years. The activity of the neoplasm has been found to increase after the injection of androgen and to decrease upon lowering the androgen level, either through inactivation of the androgens by estrogen injection or by excision of the testes.

When it becomes a matter of deciding between hormone therapy and orchiectomy, Dr. Henline expressed the opinion that in cases of advanced carcinoma of the prostate where metastases have not caused pain or distress associated with urination, hormone therapy should be employed, reserving castration for a still later phase of the disease when pain and distress have become markedly manifest. At the present time, he said, neither method will cure the patient suffering from a prostatic malignancy, although the clinical improvement in some patients appears little short of miraculous. He urged his listeners to be constantly on the alert to recognize the disease at its *early* stage, when it can frequently be obliterated by radical total perineal prostatectomy.

The paper was discussed by DRS. BUTLER, DALY, MARKOWITZ, BALSAMO, GLEESON and MACCHIA, the discussion being terminated by Dr. Henline.

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## SOMERSET COUNTY

Lancelot Ely, M.D., Reporter

The *Somerset County Medical Society* had its regular annual dinner at the Raritan Valley Farms Inn on October 11, 1945. The wives of the doctors were guests.

After the dinner the regular October meeting was held. Part of the business transacted was to arrange for the doctors at the Veterans Hospital at Lyons to be affiliated with our County Society.

The Committee also reported pertaining to the memorial stone at Pluckemin as follows:

Because of the interest shown by Dr. Benjamin Rush, physician on General Washington's staff, in erecting a marker on the grave of a British soldier in Pluckemin, the Somerset County Medical Society in June, 1945, had the fading letters of the epitaph cut deeper.

Captain William Leslie, son of the Earl of Leven, was seriously wounded during the Battle of Princeton. Dr. Rush requested Washington's permission to care for the young officer, whose family had been kind to Dr. Rush during his student days in Edinburgh. Captain Leslie died and was buried in the old Lutheran cemetery at Pluckemin. The tombstone erected by Dr. Rush was replaced in 1836 by Professor Ogilby of Rutgers College, as the original was crumbling to pieces. Dr. Rush's inscription was reproduced.

Benjamin Rush, born near Philadelphia in 1745, has been called the father of American medicine. In addition to his medical practice, he was a signer of the Declaration of Independence and pioneered in temperance, prison reform, the emancipation of slaves, and humane treatment of the insane. He established the first free dispensary in the United States. When yellow fever ravaged Philadelphia in one of the worst epidemics America has known, Dr. Rush treated an average of 125 patients a day; his treatment for the fever was copious bleeding, his usual remedy for all bodily ills. Dr. Rush was a popular and influential teacher at the University of Pennsylvania. Rush Medical College in Chicago was named in his honor.

## UNION COUNTY

Joseph J. Labow, M.D., Reporter

A regular meeting of the *Union County Medical Society* was held in Alexian Brothers Hospital, Elizabeth, September 12, 1945.

The meeting was called to order by Dr. Phelan, President, at 9:00 P. M. Dr. Phelan welcomed four members recently discharged from military service: Drs. Joseph A. Lepree, Francis J. Cronin, H. G. Mensch and Michael F. Lynch.

The minutes of the May 9th meeting and the Executive Committee meeting of September 10th were read and accepted. The resolutions on the death of Dr. John A. Quin were read and accepted.

Maurice Bruger, M.D., Chief, Division of Pathological Chemistry and Clinical Professor of Medicine, New York Post-Graduate Medical School and Hospital, New York City, was the guest speaker. His subject was "The Prevention and Treatment of Shock". A very interesting discussion followed.

Capt. Harold R. Berger, M.C., and Herbert Beohm of Elizabeth were elected to membership. Lt. Col. Jack R. Karel, M.C., transferred from King County Medical Society, Washington. Lt. Col. Karel and Dr. Michael F. Lynch were introduced to the Society and signed the Constitution.

The need for hospital facilities in Union County to provide better care for chronically ill patients and those with contagious diseases was discussed with the conclusion that existing facilities are highly inadequate, particularly in the thickly populated Eastern Union County area. It was moved that Dr. Phelan appoint an active committee to study the problem and make definite recommendations that can be acted upon by the Society.

It was announced that the next meeting will be held at the Elks' Club, 122 West Milton Avenue, Rahway, November 14, 1945.

## WARREN COUNTY

Philip B. Kassow, M.D., Reporter

The annual meeting of the *Warren County Medical Society* was held at Hotel Belvidere, Belvidere, on October 17, 1945. Ten members were present.

Dr. Bossard, the President, presented three plans for care of the veterans: The Monmouth County Plan, The Connecticut Plan, The New Jersey State Plan for treatment and examination of veterans.

A committee was appointed to further study these plans and advise the Society about them at our next meeting.

A motion was passed to amend the By-Laws, changing the County Society annual dues from $2.00 to $5.00.

A motion was made and seconded that the Treasurer, Dr. A. C. Zuck, shall pay for the annual luncheon only of the Society and the Warren County Auxiliary.

Another motion was made and seconded that the Treasurer's bill for the telephone calls and postage for the year amounting to $11.45 be approved.

The Treasurer's report was approved by an auditing committee.

Dr. Zuck reported a balance as of October 17, 1945, of $183.37.

The application for membership in the Society of Frank J. Bartolini, M.D., of Phillipsburg, was approved by Dr. Seymour Kimmel of Oxford, the censor. The Society accepted Dr. Bartolini for membership.

Dr. Bossard appointed the following nominating committee: Drs. Bauldauf, G. H. Bloom, Seymour Kimmel.

The following were nominated and elected by the Society to serve from June 1, 1946, to June 1, 1947:

President, Philip B. Kassow, Alpha
Vice-President, Walter A. Boquist, Phillipsburg
Treasurer, A. C. Zuck, Washington
Censor, Herman Bauldauf, Belvidere
Reporter, Harry Bossard, Harmony
Delegate, Harry Bossard
Three Alternate Delegates: William Varney, Ralph Buchanan and Guernsey West, Phillipsburg
Nominating Committee: Harry Bossard, Harmony.

The Woman's Auxiliary joined the Society in a luncheon.

Drs. Frank J. Bartolini and Walter A. Boquist gave intensely interesting talks on their experiences while serving in the U. S. Army.

# WOMAN'S AUXILIARY

## PRESIDENT'S ACTIVITIES

MAY 22 - OCTOBER 8, 1945

Mrs. William E. Dodd

I have the honor to submit herewith the report of your President since taking office in June. An illness which prevented my attending the annual session also revealed the many friends I have in the Woman's Auxiliary to The Medical Society of New Jersey. I was the recipient of many cards, letters and flowers. To each one of you I wish to express my sincere thanks and appreciation.

The second annual conference was called to order in Trenton on June 19th with an attendance of twenty-three. Many State Chairmen presented their working plans for the year.

I was pleased to appoint Mrs. Lodovico Mancusi-Ungaro Chairman of Safety to represent this Auxiliary for the current year in the Woman's Committee of the Newark Safety Council. Her work last year in this capacity was recognized as a very valuable contribution to the safety movement.

Meetings have been held with the Revisions, Finance and Program Committees.

My first official visit was to my home county —Ocean—on September 7th. Although Ocean has a very small active membership it is outstanding in its Blood Transfusion Fund work.

I was honored to be the guest of the Woman's Auxiliary to the Hudson County Medical Society on October 1st at their first fall meeting and luncheon. The attendance was good and the reports of the chairmen were indicative of an Auxiliary which is alive to the problems of today. They are to be congratulated upon their work and activities in Health Education.

The New Jersey State Federation of Woman's Clubs held a three-day Health Institute on Local Health Administration on October 2nd, 3rd and 4th at the New Jersey College for Women in New Brunswick. I had the privilege of representing this Auxiliary on the opening day: "Health to Build the Peace" was the theme of the program.

My day was well spent and showed clearly that other organizations have the health problems of the nation at heart. It was indicated that health is not purely physical but mental and physical as well. Mrs. A. Haines Lippincott, in her talk on Cancer, said in the five years of war twice as many lives were claimed by cancer as by war. Dr. J. Lynn Mahaffey spoke on "What We Can Do to Help Improve Health Conditions in New Jersey". He explained the duties of the different Health Departments in the state. Dr. Julius Levy, Consultant to the Bureau of Maternal and Child Health, attributed education of prenatal mothers as the greatest factor in the decrease of infant mortality. In a discussion on Venereal Disease Control Dr. Glenn S. Usher, Chief of the Bureau of Venereal Disease Control, warned that this problem is just beginning. Following each war there is a marked increase in venereal disease. Education in the school and home is vitally necessary.

It was a privilege to attend the Welfare Meeting of the New Jersey Medical Society in Trenton on October 7th. If the people of this state could realize the efforts of organized medicine to give them the right kind of medical care, compulsory health insurance would have little support.

On October 9th your President will meet with the wives of the members of the Cape May County Medical Society at Cape May Court House to reorganize their Auxiliary, which disbanded for the duration.

Other invitations which I have been delighted to accept are from Atlantic County on October 12th, Passaic County on October 15th and Essex County on October 22nd. My visits to these counties last year are very pleasant memories. It will be an honor to represent you at the Presidents' Day of the Contemporary of Newark on October 23rd.

As your President, I have endeavored to conduct the business of this Auxiliary. In so doing I have sent eighty-one letters, fifteen cards and five telegrams. The telegrams were necessary to bring in articles for the Year Book.

May I have your fullest coöperation and support in carrying out the program for the year which has been approved by the Advisory Board to this Auxiliary:

1. To promote Public Relations between The Medical Society of New Jersey and the laity and to use the resources of the Woman's Auxiliary to acquaint the people of New Jersey with the efforts of organized medicine to provide adequate medical care at a price that the people can afford to pay.

2. To give attention to controversial legislative matters and to use our influence in promoting helpful legislation and opposing harmful legislation.

3. To coöperate in reëstablishment programs for members of the medical profession who are returning from military to civilian practice and to be of aid to their families wherever possible.

4. To participate in maintaining the health of the people of New Jersey by the distribution of Hygeia and Health Education.

5. To help in making the people of this state "Safety Conscious" and thus aid in reducing accidents of all kinds.

6. To increase the circulation of the Bulletin, the national publication of the Woman's Auxiliary, in order to have a better informed working body.

7. To stress the benefits of the Society for Relief of Widows and Orphans of Medical Men of New Jersey.

8. To build a stronger, more united organization by increasing the membership of our Auxiliary.

If we accomplish these tasks assigned to us we shall have justified the reason for our existence as an Auxiliary.

## KNOW YOUR COUNTY AUXILIARY PRESIDENTS

### Atlantic County

MRS. ROBERT A. BRADLEY



Mrs. Robert A. Bradley, daughter of Mrs. Anna McGrath Scanlan and the late Frank P. Scanlan, was born in Shenandoah, Pennsylvania. After the death of her father the family moved to Philadelphia where Mrs. Bradley attended the Cathedral Parochial School and later was graduated from the Hallahan Catholic Girls' High School of Philadelphia.

On September 16, 1922, she married Dr. Robert A. Bradley of Spokane, Washington, who was then Chief Resident Physician of the Radiological Department of the Philadelphia General Hospital. On May 1, 1926, they moved to Atlantic City where Dr. Bradley has since been practicing Radiology. They have one daughter, Anne Marie.

Mrs. Bradley has been an active member of the Woman's Auxiliary to the Medical Society of Atlantic County ever since its inception in 1927, having served as Treasurer for eight years and as Second Vice-President for one year. She also has been active on various committees of this organization.

Dr. and Mrs. Bradley have been residing at 2 South Brunswick Avenue, Margate, for the past five years, having lived formerly in Ventnor and Atlantic City.

## EXECUTIVE BOARD MEETING

The Woman's Auxiliary to The Medical Society of New Jersey held its first Executive Board meeting of the fall on October 8, 1945, at the Executive Offices of The Medical Society of New Jersey in Trenton. The meeting was open to all members of the County Auxiliaries. The business session started at 10:30 a. m. with Mrs. William E. Dodd of Beach Haven, President, presiding. Reports were given by Mrs. Dodd of her activities as President and also by the special emissaries sent to the Public Health Institute sponsored by the New Jersey State Federation of Women's Clubs at The New Jersey College for Women, held October 2, 3 and 4, 1945; by the representative sent to the Woman's Division of the Newark Safety Council; and by the delegates sent to the meeting of the Welfare Committee of The Medical Society of New Jersey on Sunday, October 7, 1945. The meeting adjourned for luncheon at the Carteret Club at 1:00 p. m.

At 2:00 p. m. the meeting reconvened for a talk on "Safety in the Home from a Man's Viewpoint" given by Mr. Baumann of the Department of Safety Education of the Public Service Corporation. This was followed by the movie "What Price Happiness". The program was arranged under the auspices of the Woman's Division of the Newark Safety Council.

Following the program Dr. William E. Dodd, Chairman of the Advisory Committee of the Medical Society to the Woman's Auxiliary, greeted the Auxiliary in behalf of the Medical Society. He said all members of the Auxiliary had made contributions to help win

the war, and that their help was still needed to convert back to the peacetime way of living. Men returning are different in proportion to the service they have rendered; they are now accustomed to giving orders, and must now revert to doing many things themselves. The veterans too have formed very definite ideas as to what type of medical service they expect. The coöperation of all will be needed to carry out our objectives; and to see that the changes made are for the benefit and not to the detriment of society. In closing, he thanked the Auxiliary on behalf of the Medical Society for its loyalty and coöperation.

## AUXILIARY REPORTS

### Atlantic County

Mrs. Samuel Salasin, Chairman of Publicity

The *Woman's Auxiliary to the Atlantic County Medical Society* opened its fall season with a luncheon in honor of the State President, Mrs. William E. Dodd of Beach Haven, on Friday, October 12, 1945. The luncheon was held at the Chelsea Hotel, and was preceded by a business session presided over by Mrs. Robert Bradley, President of the Atlantic County Auxiliary. Mrs. Dodd was accompanied by Mrs. Frederick Wandall of Clayton, President-Elect of the State Auxiliary.

### Camden County

Mrs. Thomas H. McGlade, Publicity Chairman

The October meeting of the *Woman's Auxiliary to the Camden County Medical Society* was held on Tuesday, October 2, 1945. Mrs. Reuben L. Sharp presided. Mrs. Joseph E. Roberts, 201 Westmont Avenue, Haddonfield, was again our gracious hostess.

State President-Elect Mrs. Frederick G. Wandall brought greetings from the State President, Mrs. William E. Dodd. Mrs. Wandall mentioned the importance of members taking interest, not only in the functioning of the County Auxiliary, but also the State and National organizations. The Bulletin and Hygeia were emphasized as being valuable publications which should be more widely circulated.

Mrs. Harry Chandler, Jr. of Merchantville, vocalist, accompanied by Mrs. Carol Johnstone Sharp of Haddonfield, entertained with several delightful selections. Miss Beatrice Stackhouse, Haddonfield librarian, spoke on "Invitation to Reading".

### Essex County

Mrs. Rocco Marra, Chairman of Publicity

A meeting of the Board members of the *Woman's Auxiliary to the Essex County Medical Society* was held on June 8, 1945, at the home of its newly elected President, Mrs. S. Bernard Kaplan.

Most of the Board members were present and a program was set for the coming year. Mrs. Kaplan expressed her desire that full coöperation and attendance of the members would continue in the future meetings. She expressed the hope, also, that her reign would be as successful as those of the past presidents.

Following the meeting, a delightful buffet luncheon was served.

The first meeting for this year of the *Woman's Auxiliary to the Essex County Medical Society* was held Monday, October 22, 1945, at the Academy of Medicine.

Under the guidance and advisement of the Essex County Medical Society on affairs of Public Relations, the Woman's Auxiliary is planning an all-out health educational program for Essex County. There will be a series of five symposia on vital subjects of health and post war planning. The first of these was held on Monday, October 22, 1945, at 2:00 p. m. and the balance will be held on the fourth Monday of the month during the months of November, January, March and April at the Academy of Medicine. The subject for the first symposium was "The Permanent Establishment of a Blood Bank in Essex County", and the speakers were Dr. William Crecca of the Essex County Medical Society and Dr. Eugene Katzin.

### Gloucester County

Mrs. Clarence Bowersox, Chairman Press and Publicity

The *Woman's Auxiliary to the Gloucester County Medical Society* held a luncheon and business meeting at the home of Mrs. Fred Faux, Woodbury, on Thursday, September 20, 1945, at 1:00 p. m.

Mrs. Faux, President of the Auxiliary, presided at the meeting. Mrs. William Pedrick, Secretary, read minutes of the previous meeting. Mrs. George Booth of Westville gave the Treasurer's report.

Mrs. Frederick Wandall, Program Chairman, presented an outline of the program for the year and urged all members to take an active part in Hygeia subscriptions.

Mrs. Faux appointed Mrs. Ralph Hollinshed as "Widows and Orphans" Chairman and Mrs. Henry Diverty as Bulletin Chairman.

There were fourteen members present.

### Hudson County

Mrs. Sidney Chayes, Chairman of Press and Publicity

The *Woman's Auxiliary to the Hudson County Medical Society* began its meetings for the year Monday, October 1, 1945, at 2:00 p. m. at the Y. W. C. A. in Jersey City, Mrs. Edward A. Murphy, President, presiding.

The meeting was preceded by the annual fall luncheon held in the Cardinal Room of the Y.W.C.A. at 12:30 p.m. Mrs. William E. Dodd, President of the Woman's Auxiliary to The Medical Society of New Jersey, was the guest of honor. A musical program was given at the close of the business session.

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### Mercer County

Mrs. C. Chester Chianese, Publicity Chairman

The Executive Board of the *Woman's Auxiliary to the Mercer County Medical Society* was entertained at a luncheon at the Trenton Country Club on Thursday, September 20, 1945, at 1:00 p.m., by the President, Mrs. H. Donald Cowlbeck.

Following the luncheon a business session was held and the program for the coming year discussed.

It was decided that the regular meetings will be held on the first Tuesday of October, December, February, April and June.

Chairmen of various committees for this year are as follows:

Archives and History—Mrs. C. Chester Chianese
Art, Hobby and Medical History—Mrs. John F. Johnson
Bulletin and Hygeia—Mrs. R. J. Cottone
Entertainment—Mrs. Patrick H. Corrigan
Legislation—Mrs. J. J. Belfer
Parliamentarian—Mrs. Charles F. Adams
Printing—Mrs. Frank F. Commini
Public Relations, and Cancer Control — Mrs. Thomas V. Murto
Publicity—Mrs. C. Chester Chianese
Scrap Book—Mrs. Ernest F. Purcell
Widows and Orphans—Mrs. Paul J. Finegan

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The *Woman's Auxiliary to the Mercer County Medical Society* held a regular meeting at the Executive Offices of the Medical Society on Tuesday afternoon, October 2, 1945. Mrs. H. Donald Cowlbeck, President, presided.

The following standing committee chairmen gave reports:

Hygeia Chairman, Mrs. R. J. Cottone, reported that Hygeia literature had been mailed to physicians of Mercer County in order to gain new subscribers.

Cancer Control Chairman, Mrs. T. V. Murto, reported that during the April Cancer Drive, about 85 Auxiliary members joined the United Field Army for Cancer Control.

A letter was read announcing that Mrs. Eleanor Roosevelt will speak at the War Memorial Building, Trenton, on October 10, 1945. Her topic will be "Intercultural, Interracial and Interfaith Understanding". All members were cordially invited to attend.

After a brief discussion concerning the United Chest of Mercer County, the Auxiliary pledged a contribution to the 1945 Annual United Chest Campaign.

Under new business, the Nurse Scholarship Award was discussed. A motion was passed that the Auxiliary continue this project, i.e., to finance a worthy, intelligent high school graduate in training at Saint Francis Hospital. A committee was appointed to get further information concerning a student nurse.

Following the business session, tea was served.

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### Ocean County

Mrs. E. M. Sickel, Chairman of Publicity

The annual meeting and luncheon of the *Woman's Auxiliary to the Ocean County Medical Society* was held Thursday, September 8, 1945, at the home of Mrs. Leon Taylor in Cedarcroft. Attending were Mrs. William E. Dodd, President of the Woman's Auxiliary to The Medical Society of New Jersey; Mrs. Carl Menge, newly elected President of the Ocean County Auxiliary; Mrs. Carmine Pecora, Mrs. Frederick Bunnell, Mrs. Theodore F. Thompson, Mrs. Norman Szold, Mrs. Raymond Taylor and Mrs. Emanuel M. Sickel.

Mrs. Menge spoke of the year's program, placing emphasis on the importance of complete coöperation in all projects. She then introduced Mrs. Dodd who, as State Auxiliary President, explained the need in the very near future for putting into effect post-war plans contributing to faster treatment of problems confronting the returning servicemen. The Medical-Surgical Plan of New Jersey was outlined briefly as the public's solution on a voluntary basis for the maximum medical return for its investment.

Dinner was served with Mrs. Dodd as the guest of honor. Mrs. Dodd was presented with a gift as a tribute to her office as State President.

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## BOOKS RECEIVED FOR REVIEW

Pediatric X-Ray Diagnosis: A Textbook for Students and Practitioners of Pediatrics, Surgery and Radiology. By John Caffey, A.B., M.D. Chicago, Year Book Publishers, Inc. Pp. 838, illustrated. 1945. $12.50.

The Osseous System: A Handbook of Roentgen Diagnosis. By Vincent W. Archer, M.D. Chicago, Year Book Publishers, Inc. Pp. 320. $5.50.

A Manual of Surgical Anatomy. Prepared under the auspices of the Committee on Surgery of the Division of Medical Sciences of the National Research Council, by Tom Jones and W. C. Shepard. Philadelphia & London, W. B. Saunders Company. Pp. 254, with 267 illustrations on 138 figures, 153 in color. 1945. $3.00.

A Textbook of Surgery by American authors. Edited by Frederick Christopher, B.S., M.D., F.A.C.S. 4th ed. Pp. 1548 with 1483 illustrations on 762 figures. Philadelphia & London, W. B. Saunders Company. 1945. $10.00.

Pathology of Tropical Diseases: An Atlas. By J. E. Ash, Colonel M.C., A.U.S., and Sophie Spitz, M.D., C.S., A.U.S. Pp. 350 with 941 illustrations, 15 in color, on 257 plates. Philadelphia and London, W. B. Saunders Company. 1945. $8.00.

Microbes of Merit. By Otto Rahn. Pp. 277, illustrated. Lancaster, Pa., The Jacques Cattell Press. 1945. $4.00.

Rorschach's Test. II. A Variety of Personality Pictures. By Samuel J. Beck, Ph.D. Foreword by Roy R. Grinker, Lt. Col. M.C. Pp. 402. New York, Grune & Stratton. 1945. $5.00.

## BOOK REVIEWS

**Synopsis of Clinical Laboratory Methods.** By W. E. Bray, B.A., M.D. 3d ed. Pp. 528 with 93 text illustrations, 20 color plates. St. Louis, C. V. Mosby Company. 1944. $5.00.

Bray's manuals have always been a source of concise, useful information to the clinical laboratory staff and this edition is no exception. The brief synopsis of the procedures and notes on the interpretation of the results obtained are very useful to the laboratory worker. An adequate number of illustrations including microphotographs are very well reproduced.

This edition includes information regarding many new tests and additions to others and brings the data about laboratory tests up to date. The newest tests for various laboratory procedures are well described, including the identification of the sulfonamides in urine and blood and the newest methods in certain blood and urine chemistry determinations. Dr. Bray writes in a clear descriptive manner and explains only the details in the laboratory procedures which are necessary to the correct performance or interpretation of each specific test.

Phyllis Stanley, M.A., R.M.T. (A.S.C.P.).

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**Surgery of the Hand.** By Sterling Bunnell, M.D. Pp. 734 with 597 illustrations. Philadelphia, J. B. Lippincott Company. 1944. $12.00.

During the past twenty years, great strides have been made in the treatment of acute lacerations of the tendons and nerves of the hand and for acute infections. Restoration of function has been less satisfactory for older lacerations and for the "frozen hand" in which the tendons, nerves, and blood vessels are constricted and bound together by a dense mass of scar tissue.

Sterling Bunnell emphasizes certain principles of repair which may be summarized as follows: remove all constricting scar tissue; provide adequate skin covering and subcutaneous fat; repair severed nerves and tendons by direct suture or by grafting. Extensive and complicated deformities may require bone surgery and the transfer of uninjured tendons to new points of insertion for restoration of function.

He believes that the hand surgeon should be competent to do all procedures necessary for the repair of injuries or deformities in this region. His viewpoint is opposed to the present trend in our armed services, where the plastic surgeon repairs skin defects, the orthopedic surgeon repairs the tendons and bones and the neuro surgeon repairs the nerves.

The portion of this book dealing with the development and function of the intrinsic muscles of the hand contains many new and original observations, and the chapters on the management of recent and late lacerations of the tendons and nerves are the best that have thus far appeared in surgical literature.

The volume represents an important contribution to our knowledge of hand surgery by a man who is both student and surgeon. It has undoubtedly set a new standard which will influence future thought and writings on this subject.

Lyndon A. Peer, M.D.

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**The 1944 Year Book of Industrial and Orthopedic Surgery.** Edited by Charles F. Painter, M.D. Pp. 432, illustrated. Chicago, The Year Book Publishers, Inc. 1945. $3.00.

The yearly appearance of this small volume reviews the year's work in these specialties and is a handy reference book for the busy physician.

Of interest in the 1944 volume is the treatment of poliomyelitis and the much discussed Kenny treatment. There is a rather extensive section on lesions of the spine, another on fractures, dislocations and sprains and one on operative technic.

The book is well illustrated and indexed. It should interest the general practitioner as well as the specialists in orthopedics and industrial surgery.

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**Clinical Roentgenology of the Digestive Tract.** By Maurice Feldman, M.D. 2d ed. Pp. 769, illustrated. Baltimore, The Williams & Wilkins Company. 1945. $7.00.

In this second edition Dr. Feldman has added many new chapters and enlarged upon some of the clinical aspects of his previous edition. There are very few works in this field which do attempt to compactly present clinical and roentgen features and Dr. Feldman is to be commended for his painstaking effort in this undertaking. He has maintained good correlation between his well chosen and profusely illustrated films and factual material.

It is difficult to cite any one section as being outstanding. However, the material and films on the gall-bladder and large intestine merit special consideration and attention. By contrast, his section on diseases of the small intestine and its associated deficiency pattern are incomplete and somewhat sketchy. There is a tendency towards repetition of tabulated roentgen signs in the various pathological entities without attempt being made to show the impossibility of differential diagnosis of many conditions on x-ray alone. The very listing of x-ray signs under various entities becomes monotonous and detracts from the work. However, a piecemeal

dissection of this book is unjustified in view of its general high standard. A preliminary clinical presentation of each disease or defect followed by roentgen features and illustrations is a sound approach and aids in the study of such a complicated field as the digestive tract.

The work, therefore, fills a definite niche in gastroenterology. The roentgenologist, gastroenterologist and clinician can all find information of value in a careful perusal of this enormous well-planned text. Herbert Greenfield, M.D.

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**Men Under Stress.** By Roy R. Grinker, Lt. Col., M.C., and John P. Spiegel, Major, M.C., Army Air Forces. Pp. 484. Philadelphia, The Blakiston Company. 1945. $5.00.

Cruel, destructive and wasteful as war has been, there are exceedingly useful and valuable lessons that can be learned from it. Specifically it is possible to learn the methods by which men adapt themselves to all forms of stress, either in war or in peace.

The authors believe it is even a moot question whether, in the peace following conflict, the degree of stress on the average individual will be much less than that imposed by the war. Under sufficient stress any individual may show failure of adaptation, evidenced by neurotic symptoms, and such symptoms then are pathological only in a comparative sense, when contrasted with the symptoms of those still making successful adaptations. From this point of view, the psychological mechanisms under discussion in this book are those that apply to every man in his struggle to master his own environment.

The experience of the authors in military psychiatry has given them wide knowledge of combat soldiers in an active theater of operation and returnees suffering from war neuroses hospitalized for rehabilitation. They have compiled a book free of scientific jargon and of interest to anyone, either military or civilian, who is interested in human beings under stress. Carolyn Valentine, B.S.

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**Rypins' Medical Licensure Examinations;** Topical Summaries, Questions and Answers. 5th ed., revised and edited by Walter L. Bierring, M.D., F.A.C.P., M.R.C.P., Edin. (Hon.), with the collaboration of a review panel. Pp. 546. Philadelphia, J. B. Lippincott Company. 1945. $6.00.

Dr. Rypins published the first edition of his standard work on examination questions in 1933 under the title of "Medical State Board Examination Questions". Successive revisions were issued in 1935, 1937 and 1939.

The author was secretary of the New York State Board of Medical Examiners for fifteen years and his original book and its revisions, constituting four editions, were based on a critical survey of thousands of questions actually used throughout the United States. Typical questions were selected and appended to the general reviews of the various subjects.

The work covers the whole field of medicine, the basic disciplines, the specialties and medicine in general. Each section is preceded by a general review of the subject under consideration. These reviews are well written, succinct, and emphasize the important points of each subject. Technical procedures have been omitted.

After the death of Dr. Rypins the editorship of a new, enlarged edition was intrusted to Dr. Bierring, who is well qualified to carry on the work as he is secretary to the Federation of State Medical Boards of the United States and a member of the National Board of Medical Examiners.

The fifth edition carries out the original plan of separate summaries for each subject, with a selection of typical questions. The review sections were prepared by authorities in their fields. A new section on pharmacology has been added in recognition of the growing importance of this subject.

Naturally, it is assumed that the candidates are adequately trained in the medical sciences and therefore no attempt is made to teach them anything new.

A careful study of United States medical examinations indicates a general agreement among examiners regarding the material essential for candidates and the present volume adheres closely to this groundwork.

The preliminary chapter on "The Philosophy of Examinations" is interesting as it reviews the history of such examinations in the United States and Great Britain.

The National Board, of which Dr. Bierring is a member, is an important organization as its certificates are accepted by 45 state and two territorial boards in lieu of the regular licensing examinations, and also are accepted by the Board of England and Scotland for admission to the final practical examinations of these boards.

The text throughout is printed with a good large type, on soft paper, easy on the eyes, permitting of extended concentrated study without visual fatigue.

The book is recommended as a reference for all medical and public libraries. James F. Ballard.

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**One Hundred Years of Gynaecology,** 1800-1900. A Comprehensive Review of the Specialty During Its Greatest Century with Summaries and Case Reports of All Diseases Pertaining to Women. By James V. Ricci, A.B., M.D. Department of Gynaecology and Obstetrics of the City Hospital, New York. Pp. 651. Philadelphia, The Blakiston Company. 1945. $8.50.

This book is descriptive of gynecology from 1800 to 1900 and is a compilation of the birth and development of a medical specialty. It not only furnishes interesting reading, but instructive study of the development of gynecology in that period, and also valuable historical data. Research workers and others interested in the history of medicine and its various branches will find valuable reference in this book.

The remarkable advances in gynecology during the past forty-five years can only be estimated by reading this history of gynecology as presented by Dr. Ricci. Edwin Steiner, M.D.

Volume 42
Number 11



# Tuberculosis Abstracts

## *A Review for Physicians*

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

**Vol. XVIII** **November, 1945** **No. 11**

THE chest X-ray, reinforced and supplemented by a wide and wise choice of other diagnostic aids, has brought us far along the road toward control of human tuberculosis. In this year of 1945 medicine pays its sincere respects to a half century of progress in the employment of an invaluable procedure. It is a happy circumstance that we celebrate at the same time the centennial of Wilhelm Conrad Roentgen's birth.

## THE ROENTGEN RAY

X-RAY . . . new eyes for the physician . . . a new light to guide the hand of the surgeon . . . a light that can put on photographic film the record of damage done to a person's lungs by tuberculosis germs. These things we have in 1945. All because 50 years ago a scientist, at work in his laboratory, saw something he did not understand . . . but had sense enough to investigate. . . .

The scientist was Wilhelm Conrad Roentgen, professor of physics at the University of Wurzburg. From his laboratory in 1895 came the announcement that he had discovered a new kind of light.

### A New Kind of Ray

The professor was doing some experiments with cathode rays. His apparatus was a Crookes' tube, and an induction coil with a mercury interrupter —standard equipment for laboratories of the day. But, without knowing why, perhaps, Roentgen covered the tube with thick black paper so that no visible light could come through. He darkened the room completely. Then he applied current to the tube. To his amazement he saw a few brightly fluorescent crystals shining in the darkness on a table at some distance from the tube. How could this be?

He checked to see that there was no leak in the thick black paper. The fluorescence continued. He knew that the fluorescence was caused by some kind of light. But what kind? Invisible light?

What Roentgen saw had probably been seen by many before him. But he was the first to grasp its true significance, and he went to work at once to investigate and interpret his mysterious light. For days he ate and slept in his laboratory. He did not want to be interrupted in his work of putting his discovery through one test after another. Finally, after eight weeks of intense work, he released a statement "On a New Kind of Ray."

Because of the ray's unknown quality he called it X-ray. But there were many things about it that were known to him. His experiments had shown that the ray could pass through wood, paper, flesh and many other materials through which ordinary light cannot go. He noted that the ray could go through some objects more easily than through others. For example, when he held his hand between the tube and a fluorescent screen he could see the shadow of the bones in outline. Substituting a photographic plate for the screen, he made a photograph of Mrs. Roentgen's hand. The result was the first X-ray picture—a photograph showing bones and a metal ring, but no flesh.

### World Reaction

Public announcement of Roentgen's discovery brought instant attention. The world of science and medicine was quick to see the benefits that the new ray would bring to mankind. If Roentgen could use his "light that never was on land or sea" to make such a photograph of his wife's hand, why couldn't it be used to show broken and diseased bones, or even diseased organs of the body?

Magazines of the day carried articles that marvelled at, as well as made fun of, the discovery. News of Roentgen's rays rivalled the headlines

of the Boer war in the daily papers. Who was this man whose name was suddenly known to everyone?

## The Man

Wilhelm Conrad Roentgen was born in Lennep, Germany, on March 27, 1845. Home, however, was Apeldoorn, in Holland, where his merchant father moved the family when Wilhelm was three years old. His boyhood and early school days in Holland were like that of most boys. In fact, he was not considered a very good or serious student.

His first interest in science came at the Zurich Polytechnical School in Switzerland where he had the good fortune to study with August Kundt, an experimental physicist. Roentgen was preparing to be an engineer, but he spent much of his time in Kundt's laboratory. After he graduated in engineering, he took a degree of doctor of philosophy with a study on gases. As he put it, "I had two diplomas, one as an engineer and the other as a Ph.D. . . . however I could not bring myself to go into engineering. . . . He (Kundt) told me to try physical science. . . . In short, at the age of 24 years, and already practically engaged, I began to experiment and to study physics . . ."

He was "practically engaged" to Bertha Ludwig whom he married in 1872. The Roentgens then set out on a career which took them to universities in Wurzburg, Strassburg, Hohenheim, Giessen, and back to Wurzburg. At the University of Wurzburg he and Bertha spent their happiest years.

## World Acclaim

The happy routine at Wurzburg was, of course, affected by the discovery of what his colleagues now called Roentgen rays. He lectured on his discovery before the Physical Medical Society in Wurzburg early in January, 1896. He was asked to give a personal demonstration of the new rays before Kaiser Wilhelm II. Other invitations came for him to speak, but Roentgen made a policy of refusing. Universities began to bid for his services. Finally in 1900 he accepted the call to head the Physical Institute at the University of Munich. A year later he received the Nobel prize for physics—the first year of the award.

For some twenty years until his death in 1923, in Munich, Roentgen saw phenomenal development of his rays. Industry, agriculture, art and countless other fields besides medicine and science fitted it to their uses.

## X-ray in Tuberculosis

Benefits of Roentgen's ray are striking in the fight against tuberculosis. Before X-ray the physician had to depend upon sound and touch to find tuberculosis. By the use of X-ray, however, tuberculosis can be discovered in its early stages; treatment can be begun when it will do the most good. Today new and improved X-ray equipment makes low-cost X-ray examination of the chest possible for everyone. Such mass X-raying of apparently healthy people gives new hope for the complete elimination of tuberculosis.

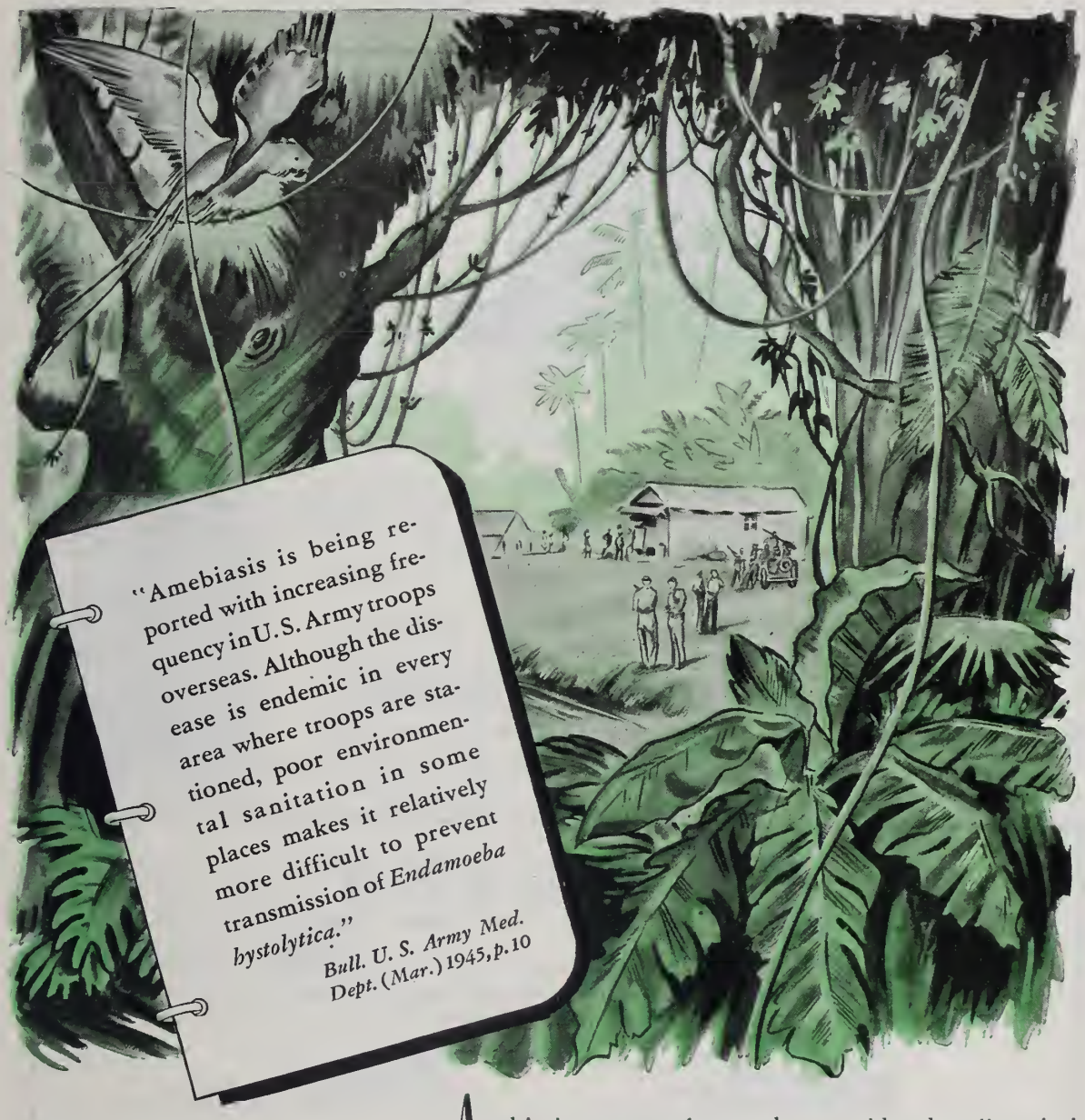
To the zeal and creative genius of a scientist will go much of the credit for this promised conquest of disease. For, although X-ray equipment has undergone notable development, the principle of the X-ray itself remains the same as when laid down by Wilhelm Conrad Roentgen in his laboratory on November 8, 1895.

*(The contents of this issue of TUBERCULOSIS ABSTRACTS, adapted for lay distribution, are available in the form of an anniversary "Roentgen" leaflet. If you wish a supply for your patients, please apply to the tuberculosis association in your community.)*

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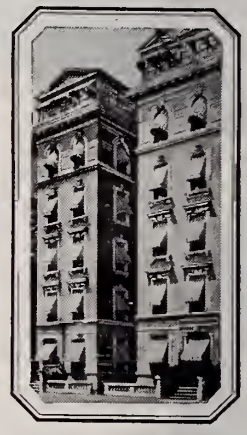
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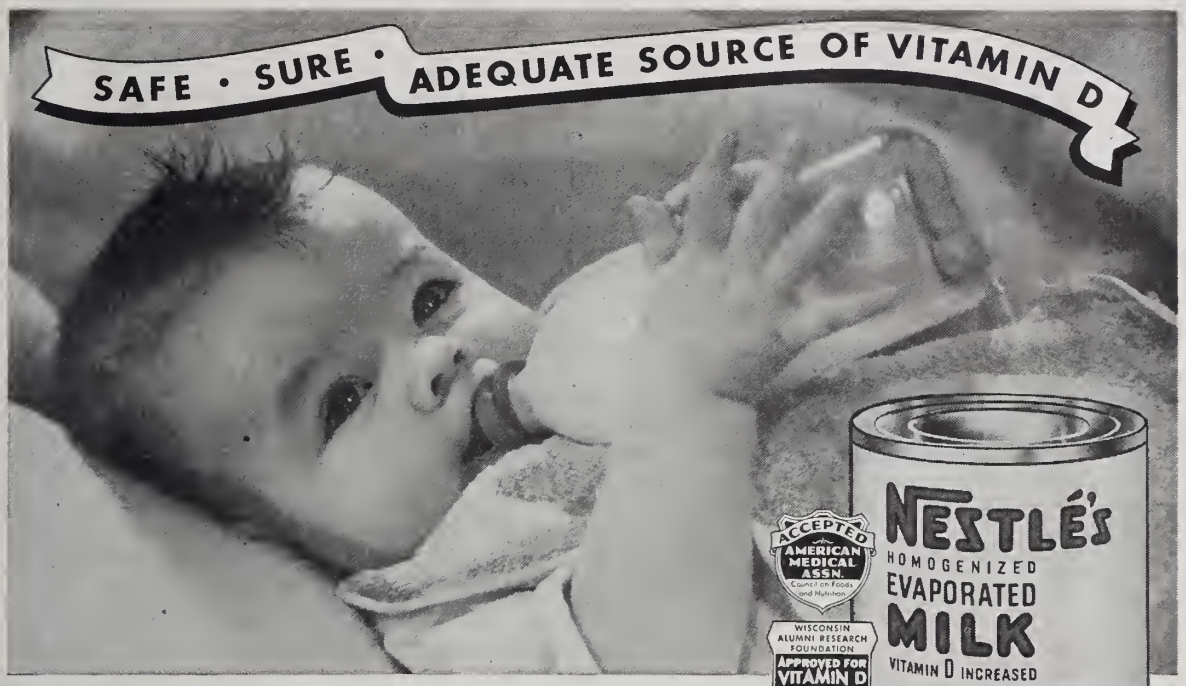
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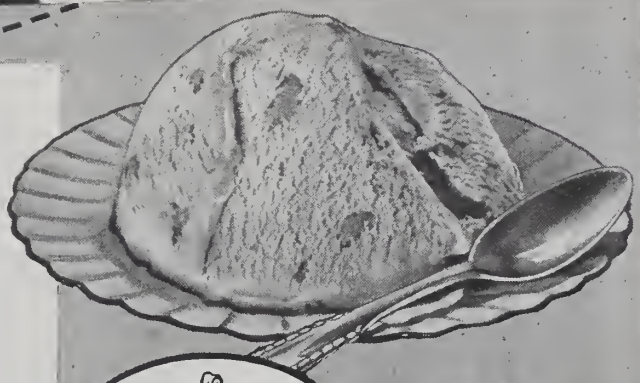
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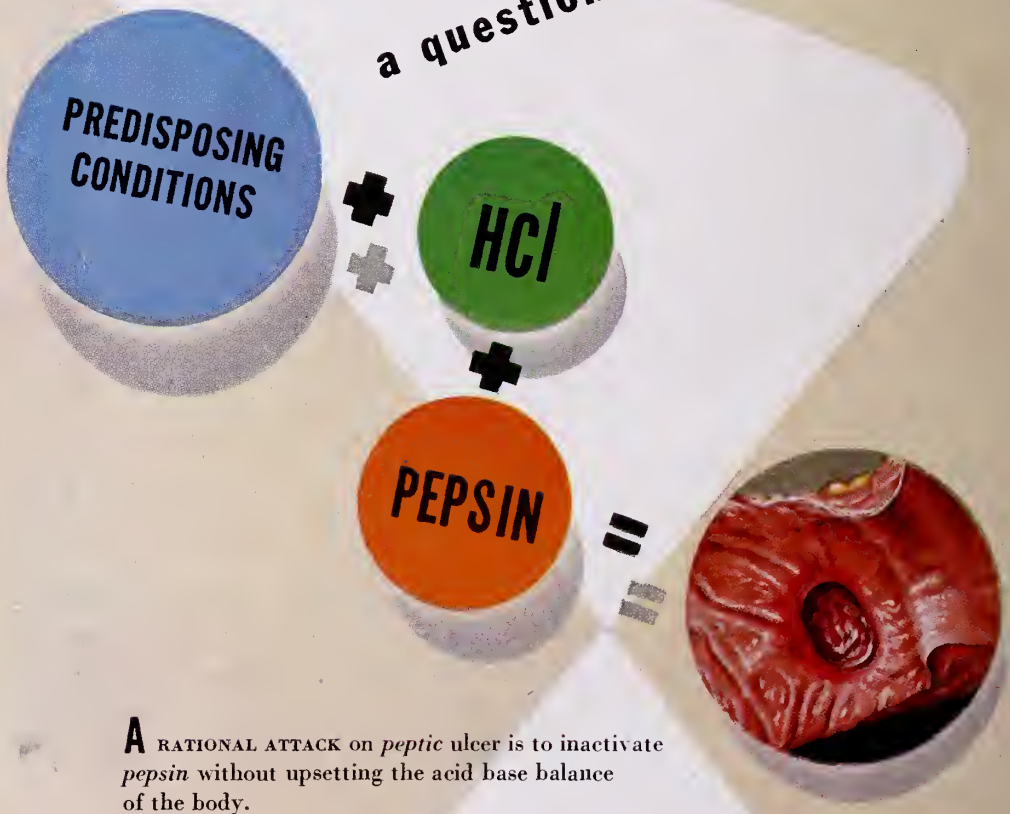
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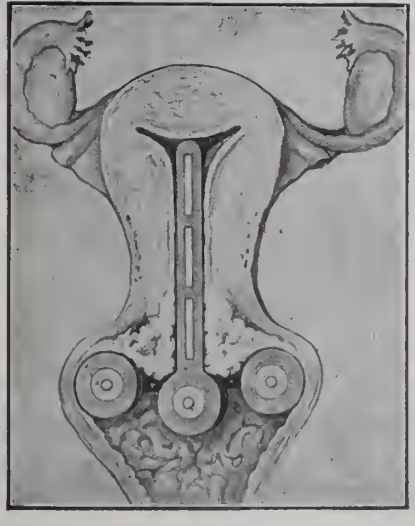
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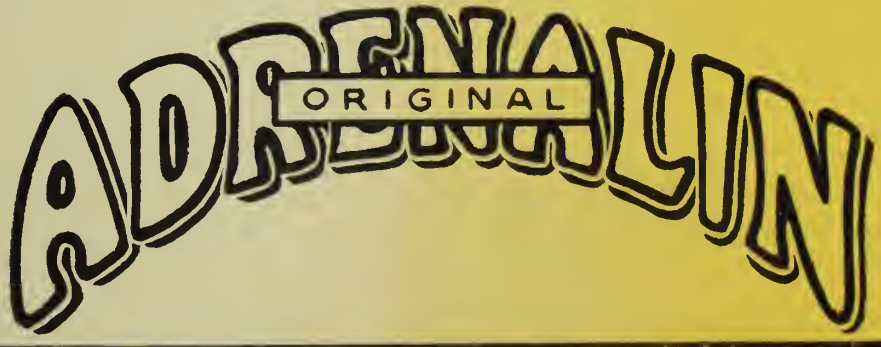
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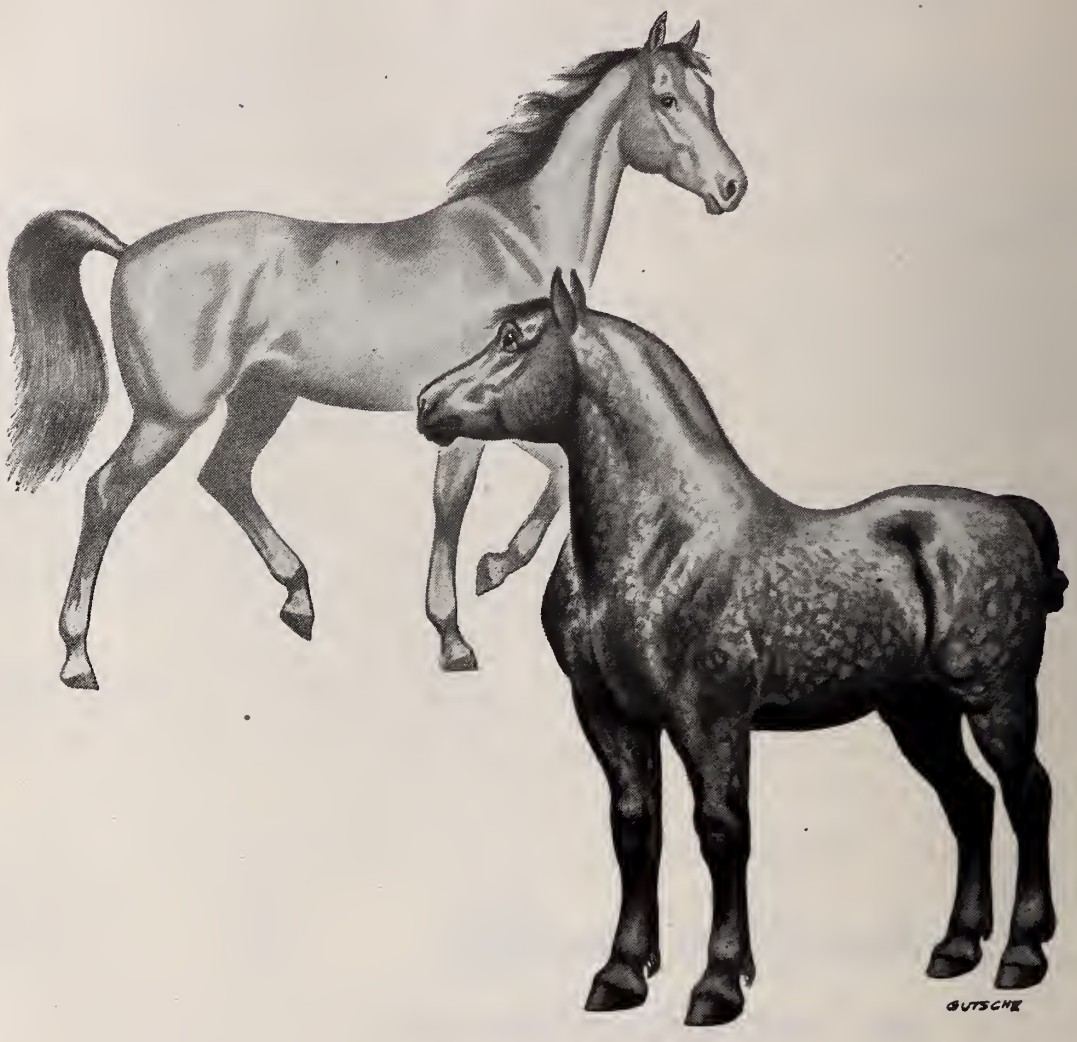
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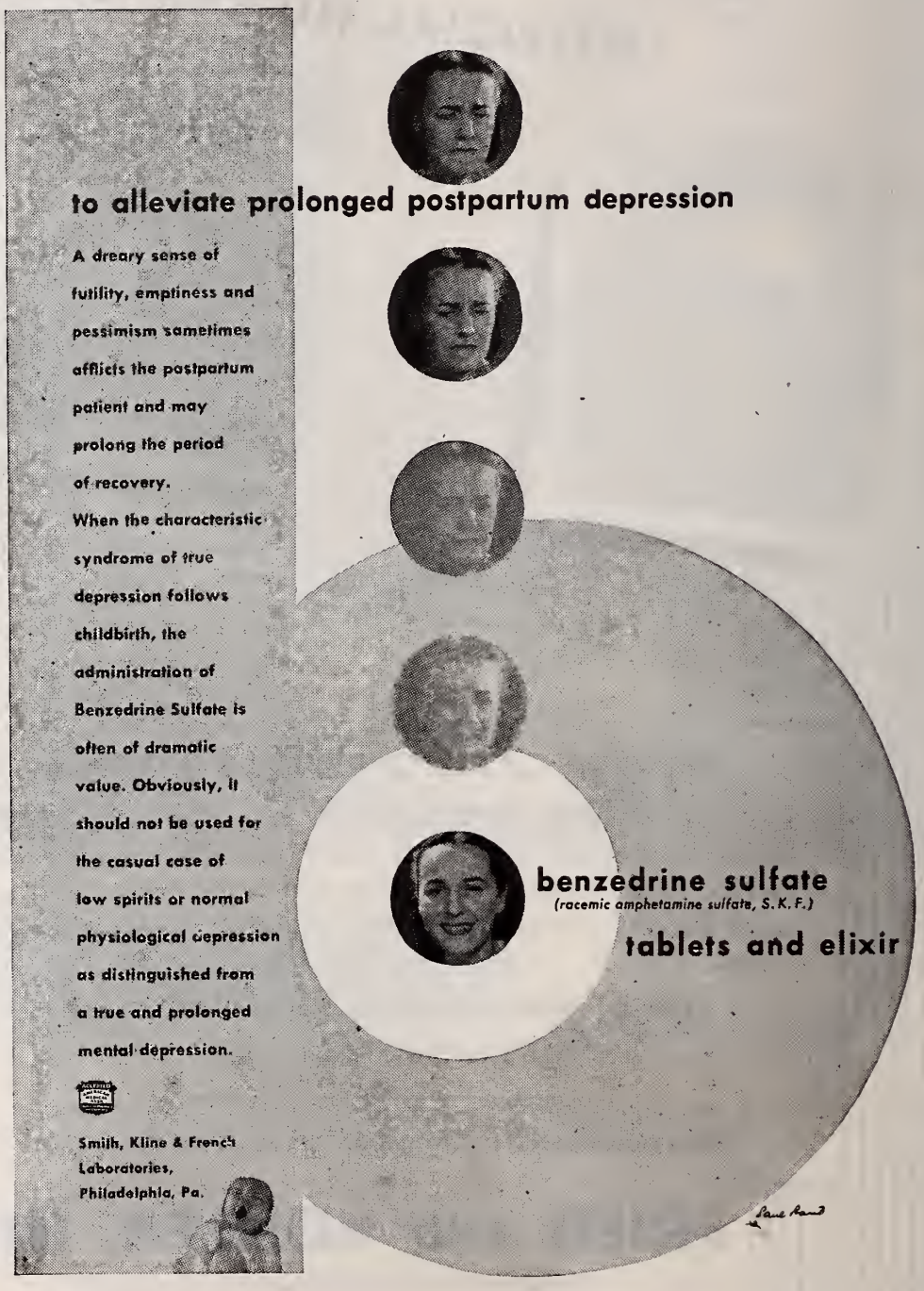
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Pain, fever, edema, leucocytosis, sense of fullness and impaired hearing.

*Treatment*

Relief of pain and inflammation—*Auralgan.*

*Action*

Decongestant, analgesic, bacteriostatic.



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Persistent discharge, often foul smelling, usually no toxemia, no pain, no fever.

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***Q. What are the ingredients in Campbell's Strained Baby Soups?***

*A.* Campbell's use carefully selected meats, cereals and those vegetables scientifically recognized as having the most desirable nutritive qualities. All the food properties are natural. Because Campbell's are accustomed to purchasing only selected meats and vegetables, the best is assured for Campbell's Strained Baby Soups.

***Q. What about vitamin and mineral retention?***

*A.* The latest scientific information has been drawn upon in the development of a cooking method to insure the effective conservation of vitamins and retention of minerals.

***Q. When should Baby be started on strained soups?***

*A.* Campbell's Strained Baby Soups can be started as early as any strained baby foods. Depending upon the baby, pediatricians recommend beginning between the ages of three and six months.

***Q. Why do Campbell's Strained Baby Soups taste better?***

*A.* The superior flavor is the natural result of the high quality meats and vegetables, together with Campbell's many years of experience in making soups that taste good. This flavor superiority has been substantiated by the enthusiasm with which these soups were welcomed upon their introduction to doctors and mothers in Philadelphia, some months ago.

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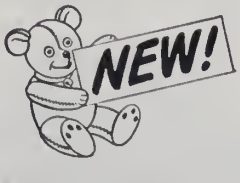
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Campbell's Strained Baby Soups represent fine quality . . . in ingredients . . . in care and method of cooking . . . in retention of minerals and conservation of vitamins . . . *and in good flavor.* Every resource of Campbell's Kitchens is devoted to that aim.




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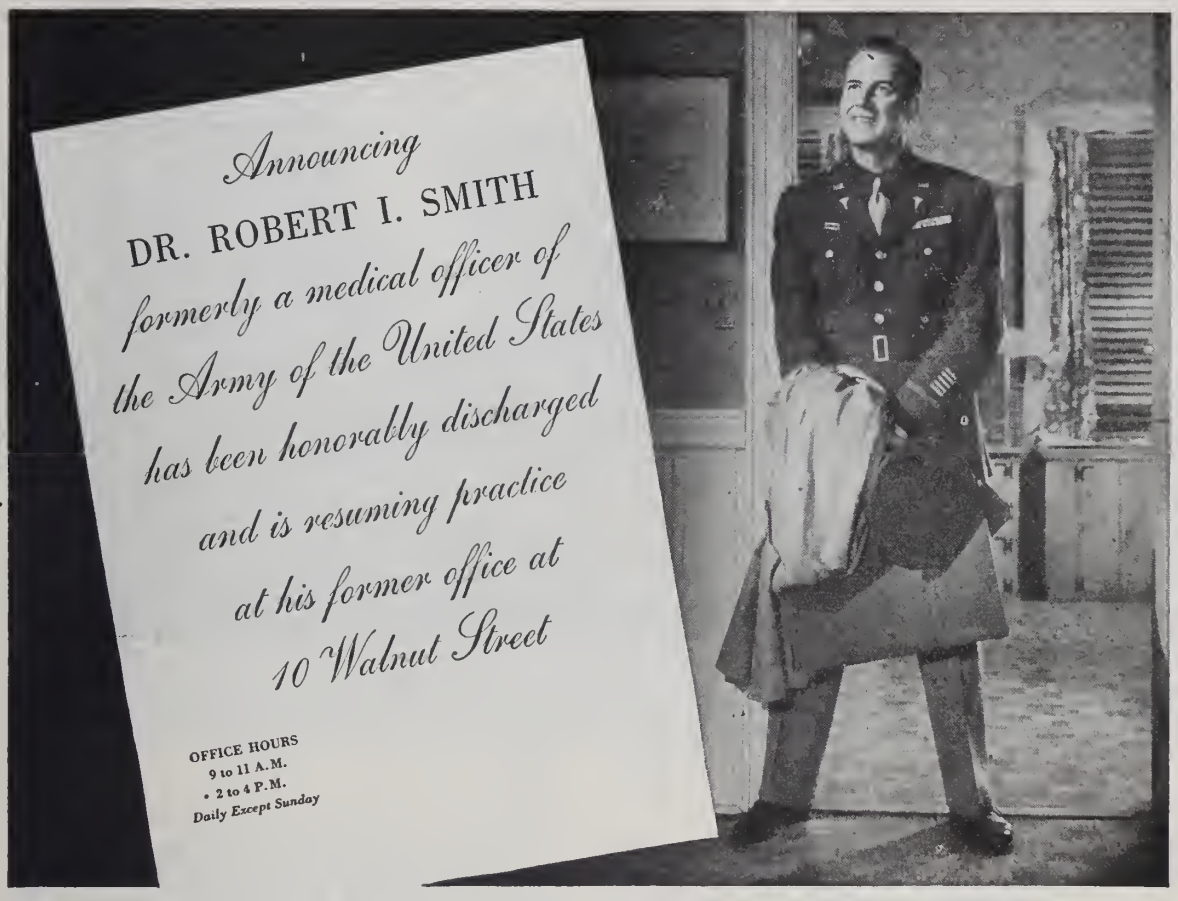



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* For approved uses of oral penicillin see C. S. Keefer, et al., J.A.M.A., 128:1161, 1945

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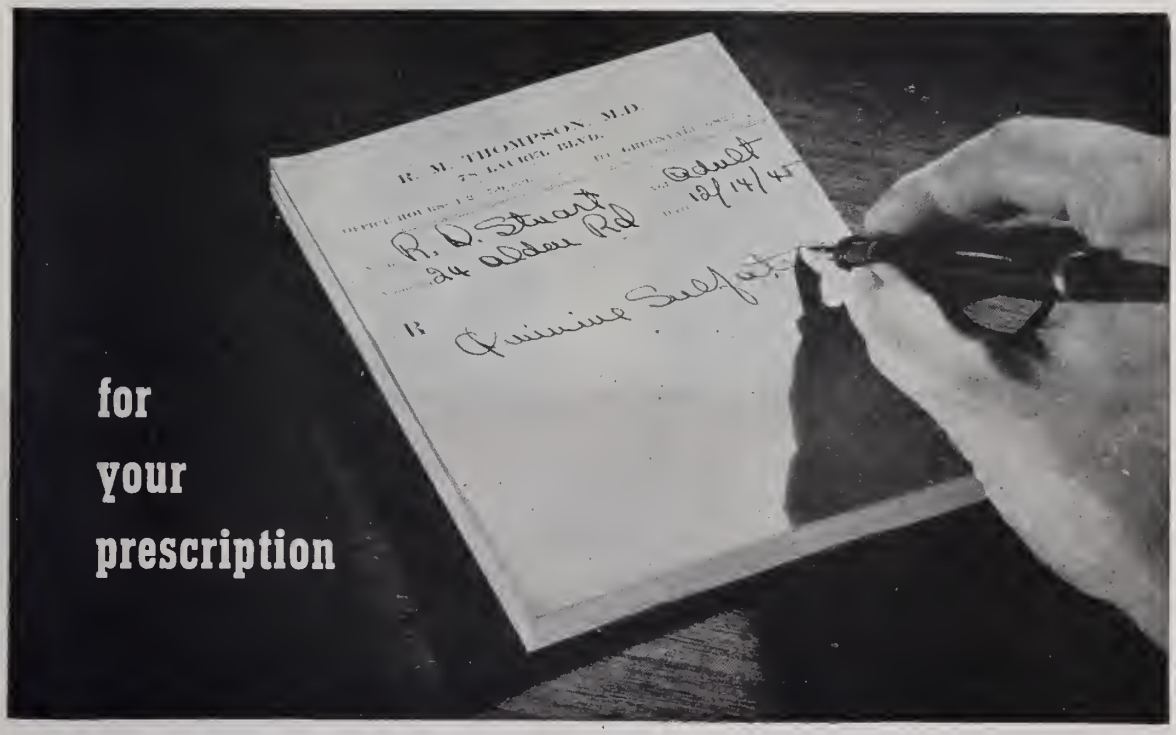
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1. Their *basic construction* assures rest and protection to the spine . . .

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Mesopin is a selective antispasmodic whose action is especially directed toward the gastrointestinal tract. Its spasmolytic effect is similar to that of atropine, but without objectionable side actions.

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Each tablet of Mesopin contains 2.5 mg. homatropine methyl bromide. Mesopin with Phenobarbital contains, in addition, 20 mg. phenobarbital. Mesopin and Mesopin with Phenobarbital are available in bottles of 20, 100, 500, and 1000 tablets.






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That's why the Boston Health Department made the following test, which proved that the purity of Certified-Pasteurized is little short of miraculous:

**GROWTH OF COLONIES OF BACTERIA FROM A CUBIC CENTIMETER OF MILK**

| TYPE OF MILK | NO. OF SAMPLES | | NO. OF COLONIES | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | ON DELIVERY | 1 DAY AT 40°F. | 2 DAYS AT 40°F. | 3 DAYS AT 40°F. | 4 DAYS AT 40°F. | 5 DAYS AT 40°F. |
| Certified-Pasteurized | 22 | Maximum | 20 | 40 | 100 | 850 | 1000 | 1400 |
| | | Minimum | 0 | 4 | 5 | 8 | 15 | 20 |
| | | Average | 8 | 14 | 44 | 157 | 286 | 770 |

• In discussing this table, the chemists stated that *even after ninety-six hours in the refrigerator*, Certified-Pasteurized still "conformed to the bacterial standards and was perfectly safe for use as measured by present knowledge of the subject."

The report . . . the complete results of which appeared in the *New England Journal of Medicine* . . . was made by the Laboratory for Chemistry and Sanitary Biology, Boston Health Department. If you'd like to have a reprint of the entire study, write to Walker-Gordon, Inc., Plainsboro, N. J.

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DURING THAT

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FIRST YEAR OF LIFE





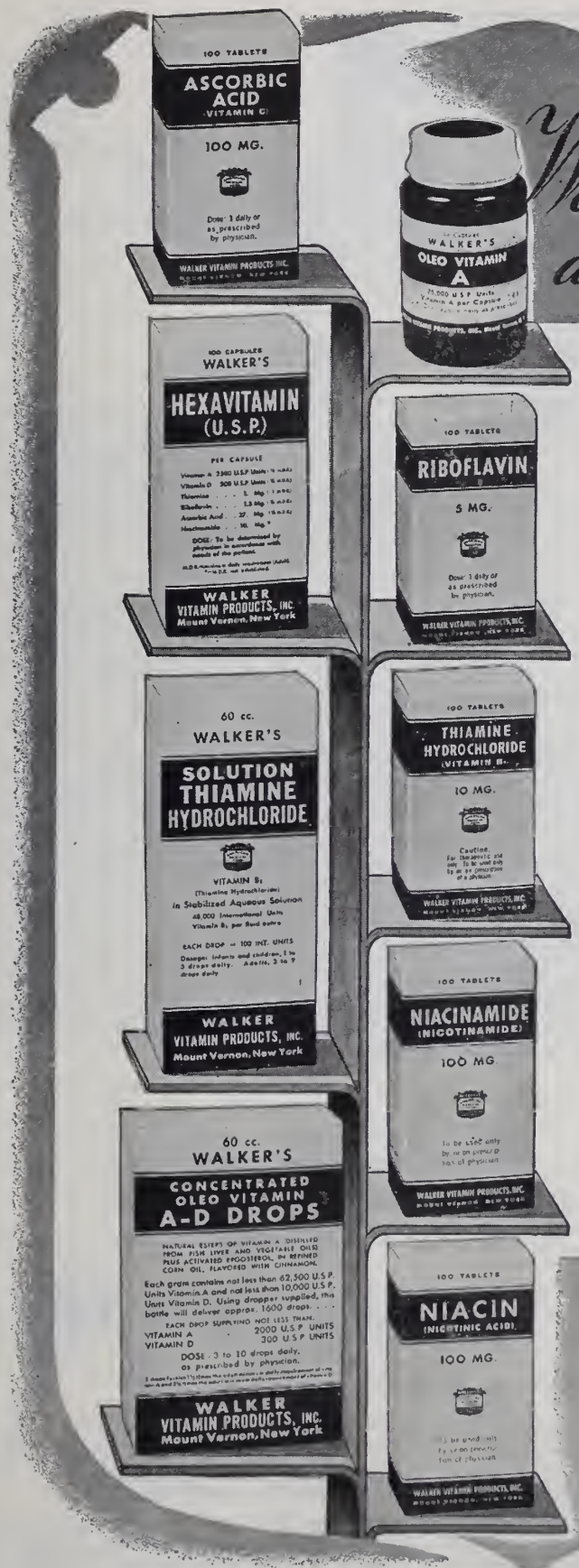

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ACCEPTED AMERICAN MEDICAL ASS'N Council on Foods

A powdered, modified milk product especially prepared for infant feeding, made from tuberculin tested cow's milk (casein modified) from which part of the butter fat is removed and to which has been added lactose, olive oil, cocoanut oil, corn oil and fish liver oil concentrate.

**SIMILAC** } **SIMILAR TO HUMAN MILK**

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. . . Good for physicians to prescribe because they fill real therapeutic needs with efficiency, and conform to the highest ethical standards of quality. Good for patients to take because careful laboratory control assures consistent uniformity of vitamin potencies, and because they are convenient to take. Good also, because they offer physician and patient alike, pharmaceutically elegant vitamin preparations at commendably low prices.

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**Riboflavin**
(1 Mg., 5 Mg.)

**Ascorbic Acid**
(25 Mg., 50 Mg., 100 Mg.)

**Niacin**
(25 Mg., 50 Mg., 100 Mg.)

**Niacinamide**
(25 Mg., 50 Mg., 100 Mg.)

**SOLUTIONS**

**Solution Thiamine Hydrochloride (Oral)**
(100 I.U. per drop)

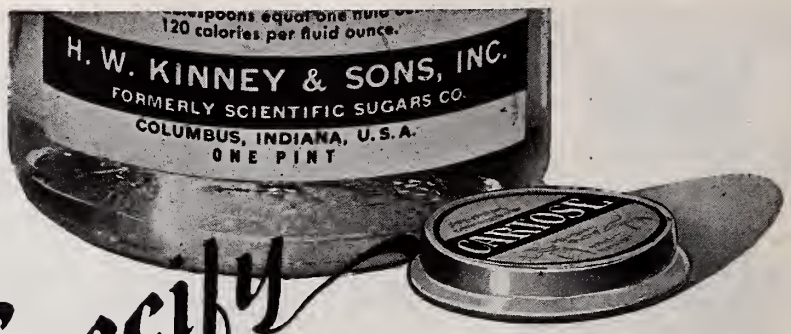
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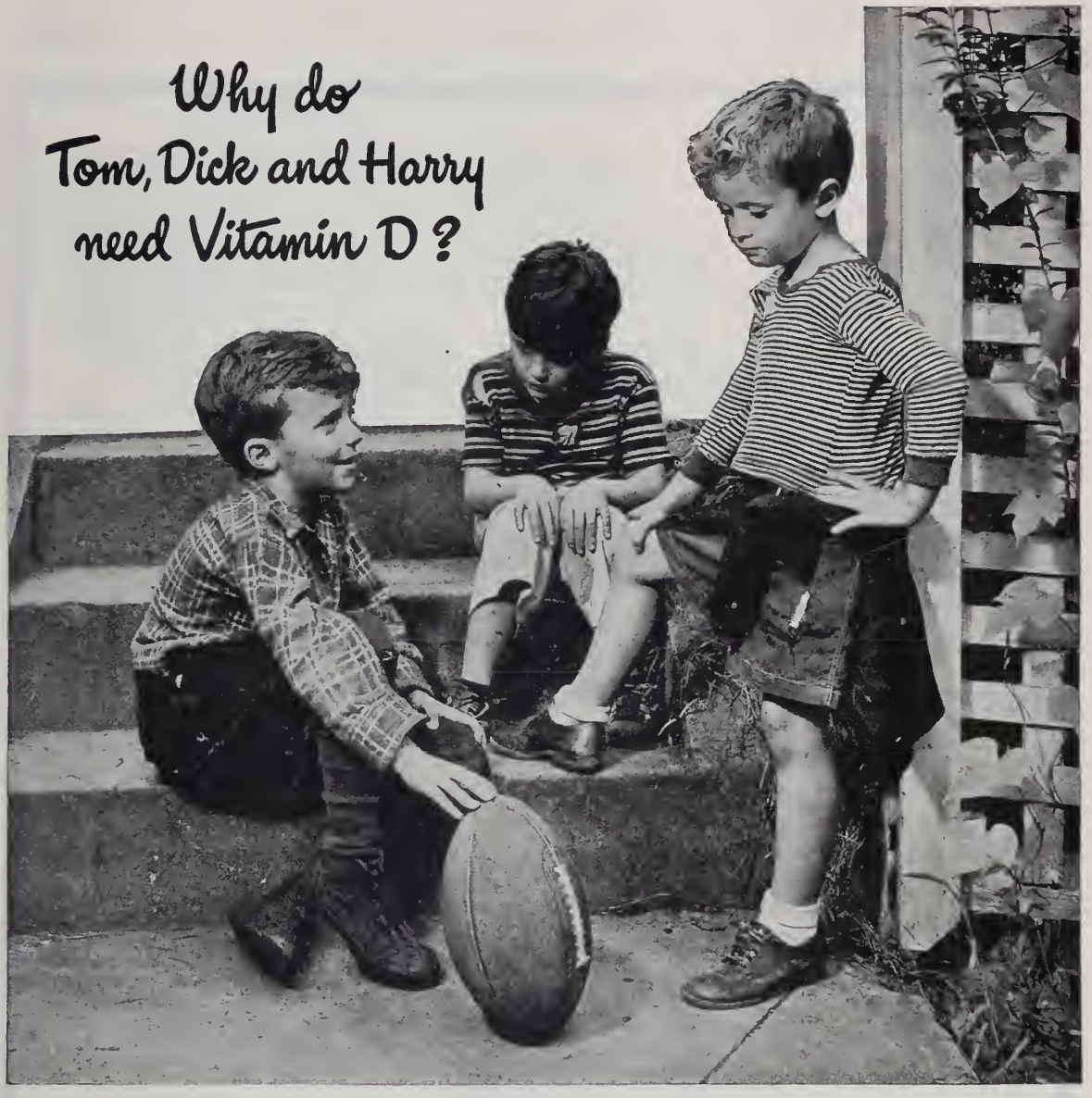
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**THERAPEUTIC APPRAISAL:** Quick acting, long lasting . . . nasal decongestion without compensatory recongestion; relatively free from cardiac and central nervous system stimulation; consistently effective upon repeated use; no appreciable interference with ciliary activity; isotonic to avoid irritation.

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**SUPPLIED** as ¼% and 1% in isotonic salt solution, and as ¼% in isotonic solution of three chlorides (Ringer's), bottles of 1 fl. oz.; ½% jelly in ⅜ oz. collapsible tubes with applicator.

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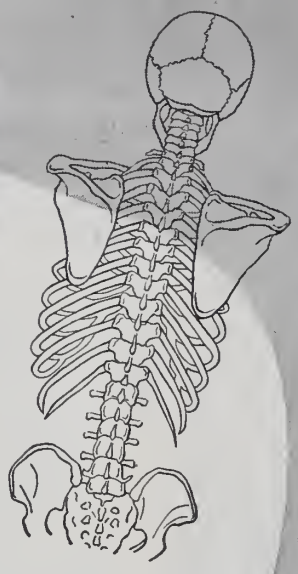

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*McCune, W. S., and Evans, J. M.: Intraventricular Penicillin in the Treatment of Staphylococcic Meningitis, J. A. M. A. 125:705 (July 8) 1944.

Gould, A. H.: Mixed Bacterial Meningitis Following Cranio-Cerebral Trauma, Rocky Mountain M. J. 41:560 (Aug.) 1944.

MacNeal, W. J., and Pease, M. C.: Fulminant Meningococcemia Treated with Penicillin Calcium, Am. J. Dis. Child. 68:30 (July) 1944.

Rosenberg, D. H., and Arling, P. A.: Penicillin in the Treatment of Meningitis, J. A. M. A. 125:1011 (Aug. 12) 1944.

Sweet, L. K.; Dumoff-Stanley, E.; Dowling, H. F., and Lepper, M. H.: The Treatment of Pneumococcic Meningitis with Penicillin, J. A. M. A. 127:263 (Feb. 3) 1945.


## PENICILLIN-C. S. C.

In meningitis, when penicillin is given intrathecally as well as systemically, the state of purification reached in Penicillin-C.S.C. is especially appreciated. The reactions to penicillin, attributed by many investigators to inadequate purification, are minimized when Penicillin-C.S.C. is used. Rigid laboratory control, and biologic and bacteriologic assays, safeguard the potency, sterility, nontoxicity and pyrogen-freedom of Penicillin-C.S.C. For this reason, and because its large production spells adequate supplies as needed, Penicillin-C.S.C. has been given preference in many of the country's outstanding hospitals.

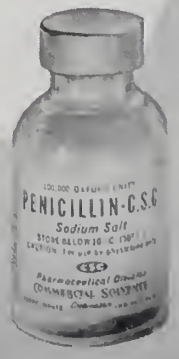
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ACCEPTED AMERICAN MEDICAL ASSN Council on Pharmacy and Chemistry

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Convoys are no longer necessary in the Atlantic as a safeguard against hostile action.
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1.—Smull, K., Wégria, R., and Leland, J., J.A.M.A. 125:1173 (Aug. 26) 1944.
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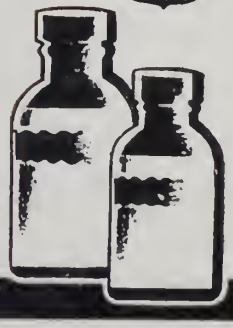
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Patients on "Premarin" therapy usually experience a general feeling of well-being in addition to relief of symptoms; this is confirmed by most of the many clinical reports. Rendering the patient symptom-free is, of course, the prime consideration of treatment; many physicians, however, feel that the restoration of a brighter mental outlook is also an important consideration when instituting therapy. "Premarin" will be found to exhibit the desirable characteristics of both the natural estrogens and the synthetic substances. Although highly potent, "Premarin" is derived exclusively from natural sources; it is exceptionally well tolerated, and unpleasant side effects are seldom noted.

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*WELL TOLERATED*

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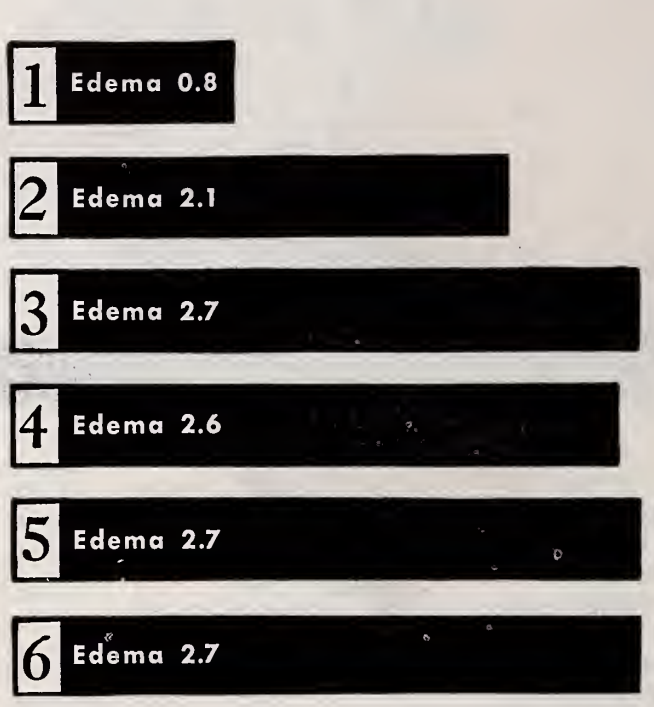
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**CONCLUSION:*** Results show that regardless of blend of tobacco, flavoring materials, or method of manufacture, the irritation produced by all ordinary cigarettes is substantially the same, and measurably greater than that caused by PHILIP MORRIS.

**CLINICAL CONFIRMATION:**** When *smokers* changed to PHILIP MORRIS, substantially every case of irritation of the nose and throat due to smoking cleared completely or definitely improved.

**N. Y. State Journ. Med. 35 No. 11,590* ***Laryngoscope 1935, XLV, No. 2, 149-154*

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With children . . . "... the benzedrine inhaler can be satisfactorily employed for young children for the relief of obstructive symptoms in the nasopharynx due either to infection or to allergic edema. No untoward symptoms were noted from the use of the inhaler."

Vollmer, E.S.: Use of the
Benzedrine Inhaler for Children, Arch. Otolaryng. 26:91.

Benzedrine Inhaler a better means of nasal medication




In a recent survey of pediatricians, 77% were found to use Benzedrine Inhaler, N.N.R., in their practice.

Children accept Benzedrine Inhaler therapy willingly, and show none of the hostility which so often complicates the administration of drops, tampons, or sprays. Each Benzedrine Inhaler is packed with racemic amphetamine, S.K.F., 200 mg.; menthol, 10 mg.; and aromatics. Smith, Kline & French Laboratories, Philadelphia, Pa.

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The urinary tract is sharply outlined with the use of NEO-IOPAX for intravenous urography. Calices, pelvis and ureter are clearly visualized within 5 to 10 minutes.

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There is much to be done if we are in some small measure to repay those who fought for us.

For those who died there are families to care for; those who were hurt must be brought back to health; and even those who returned without physical injury need to be helped back to a normal peacetime existence.

". . . to the great task remaining before us."

**BUY VICTORY BONDS**

They finished their job; let's finish ours.



**Upjohn**

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A comprehensive report published in *Human Fertility*[1] shows an overwhelming preference by experienced clinicians for the "Diaphragm and Jelly" method of conception control.

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1. Human Fertility, 10:26, March, 1945.




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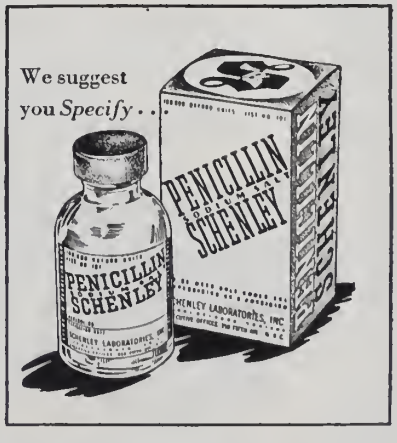


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***Product of a common mold . . . but most uncommon care***

The mold which produces penicillin is a mold of a fairly *common* variety . . . but the production of penicillin for the medical profession depends upon precautions to insure sterility which are *most uncommon.*

One of the most important requirements of the finished penicillin is freedom from pyrogens. Each manufactured lot of PENICILLIN SCHENLEY is tested (as illustrated above) to insure utmost pyrogen-freedom. When, in placing your order for penicillin, you specify PENICILLIN SCHENLEY . . . you may do so with confidence . . . knowing that such measures of uncommon care assure a product of highest standards.




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*Indicated therapy in Sequelae of*

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**2½ grains**

Physicians in private practice as well as in neurological clinics have widely prescribed these pills since 1929, and their continued interest in and use of them point to the serviceability of this therapy.

Stramonium Pills (*Davies, Rose*) exhibit in each pill 2½ grains of alkaloidally standardized Stramonium (powdered dried leaf and flowering top of Datura Stramonium, U.S.P.), equivalent to 25 minims (1.54 cc.) of Tincture U.S.P.

As a reassurance of the activity of the finished pills, they, too, are alkaloidally assayed, thus establishing as far as possible uniformity and dependability.

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Any *one* of the *many advantages* singularly inherent in TAMPAX might well serve to bring a woman greater "peace of mind" during the menses. Indeed, many patients have told their physicians that — since Tampax fits so comfortably in situ, making them "hardly aware of its presence"— it enables them to "forget that they are menstruating", so they are free from much of the "disturbing annoyance they had every time they menstruated."[1]

In addition to providing this "natural" *comfort*, TAMPAX has proved so thoroughly *adequate* and *safe*[1,2,3]...and so successful in overcoming problems associated with the external pad such as odor, vulvar irritation, and chafing,[1,2,3] and of conspicuous bulging... and, finally, allows of so much wider a range of activity during the period... that women everywhere are fast becoming "converts" to this newer, pleasanter, internal form of protection pioneered by a physician.

Tampax is available in three absorbencies: "Regular", "Super" and "Junior". *The coupon below is for your convenience.*







*References:* 1. West. J. Surg., Obst. & Gyn., 51:150, 1943. 2. Clin. Med. & Surg., 46:327, 1939. 3. Am. J. Obst. & Gyn., 46:259, 1943.

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'Dexin', palatable but not too sweet, is readily soluble in hot or cold milk or other bland fluids. 'Dexin' does make a difference.

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## 'Dexin'

HIGH DEXTRIN CARBOHYDRATE

Composition—Dextrins 75% • Maltose 24% • Mineral Ash 0.25% • Moisture 0.75% • Available carbohydrate 99% • 115 calories per ounce • 6 level packed tablespoonfuls equal 1 ounce • Containers of twelve ounces and three pounds • Accepted by the Council on Foods and Nutrition, American Medical Association.

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THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

PUBLISHED MONTHLY SINCE SEPTEMBER, 1904
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UNDER THE
DIRECTION OF THE
COMMITTEE ON PUBLICATION




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VOL. 42, NO. 12 DECEMBER, 1945 Subscriptions, $3.00 per Year
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# EDITORIALS

## WHO WILL WIN AND WHO WILL LOSE?

*Who Will Win?*

Who will win if national compulsory sickness insurance is inaugurated in this country?

1. A few physicians who are willing to practice mass medicine, who are willing to abandon the ideals of medicine and render an indifferent, impersonal type of low standard service to the public.

2. A large group of politically minded job hunters who would receive pork-barrel appointments as administrators of a vast governmental bureau.

3. Certain politicians, until the time of reaction arrived as a result of the demonstrated defects of compulsory sickness insurance.

*Who Will Lose?*

1. The tax-payer who will be burdened with a tax for which he receives little in return.

2. The non-tax payer, the poor, who now receive the best of medical care from our best physicians in accordance with the ideals and traditions of the profession, and who are not provided for under the compulsory program.

3. The public, the gullible public, who accept without question the promises and arguments of politically ambitious persons in favor of national socialism.

4. Industry, which will be taxed a portion of its profits to support a program resulting in more work days lost. This portion of its profits might better be devoted to the salaries of employees to give them more real security.

5. Our community hospitals, which will be forced to abide by governmental regulations and to adjust their standards of service to the lower per diem payment allowed under the Scheme.

6. Our Blue Cross Plans which have

demonstrated that the cost of hospitalization can be met for the majority of our people on a voluntary, democratic basis.

7. Our children and our children's children because of lowered health and health standards and through relieving them of the sense that they must be responsible for their own welfare.

8. Our labor unions who disregard the warning of their great leader, Samuel Gompers, when he said in 1916, "For a mess of pottage, under the pretense of compulsory social insurance, let us not voluntarily surrender the fundamental principles of liberty and freedom, the hope of the Republic of the United States, the leader and teacher to the world of the significance of this great anthem chorus of humanity—liberty!"

---

## MEDICAL AND HOSPITAL SERVICE PLANS THE ONLY ALTERNATIVE

Recent events place medicine in a more critical position than has existed during its entire history.

President Truman's message to the Congress on November 19 recommending national compulsory sickness insurance has had a profound influence on public opinion. It has inspired the proponents of compulsory sickness insurance with a new confidence of success. President Truman, though a product of the new deal, had gained the support of a great new mass of people because of his previous conservative actions supported by his independent and Western background and philosophy. The fact that he now recommends compulsory sickness insurance has influenced many of these people in its favor.

We know that the President is wrong. We know from our experience in New Jersey that compulsory taxation is not necessary to assure the patient a reasonable economic protection against the cost of medical care. Such taxation will not be demanded by our people if the medical profession present a solid front in supporting their own Plans.

We know that the medical economic problem of self-supporting employed persons, as covered by the Wagner Bill, can be solved by the people themselves with the coöperation of hospitals and the profession through the insurance principle.

We know that the poor, the indigent and the medically indigent, of New Jersey need a complete medical care program payable by tax subsidy and that such a program is not provided for in the Wagner Bill. We know that self-supporting employed persons in New Jersey do not need and do not want to pay for a complete medical care program. They want protection against the cost of hospitalization and serious or catastrophic illnesses.

We know too that some physicians in New Jersey are indifferent to this problem and to the efforts of organized medicine to find a solution. For their information we review the three types of Plans so far evolved. They are the only alternatives so far evolved for national compulsory sickness insurance. The movement is young. It needs the support of every physician in every community in New Jersey.

1. *Group Health Association:*

A group health association is usually a corporation. The corporation employs physicians on a salary basis and resells the services of these physicians to its subscribers who pay subscriptions to cover the costs on a prepayment insurance

basis. Such an organization is typified by the "Kaiser Plan". Organized medicine has not given approval to such arrangements because they involve selling the personal services of physicians by a third party, a corporation.

2. *Indemnity Plans:*

Indemnity plans are typified by the plans offered by lay insurance companies and by some medical society sponsored plans. They allow free choice of physician and no third party is injected between the physician and his patient. They have the approval of organized medicine. Indemnity plans provide funds by which the expense of the patient is at least partly met and any remaining expense, regardless of the income of the patient, is a responsibility of the patient. They usually are limited to indemnity toward the cost of surgical procedures rather than the cost of the care necessary in the treatment of the disease as it affects the individual. Some of the newer indemnity plans do include both medical and surgical benefits. The majority of indemnity plans are limited to surgical procedures among employed persons and do not include dependents.

3. *Service-Indemnity Plans:*

Service Indemnity Plans stipulate that participating physicians will deem as full payment for eligible services the amount paid by the Plan for services rendered certain groups of people, usually those people with annual incomes below the income levels stated in the contract of the Plan. For services rendered persons of higher incomes the payments of the Plan are considered indemnity toward the fee agreed upon between the patient and the physician. Such plans require the coöperation of participating physicians who agree to carry out the provisions of the contract of the plan. The subscription rate is adapted to support fees considered to be fair fees for persons with incomes below the level stated in the contract. Such a plan is typified by Medical-Surgical Plan of New Jersey, organized by The Medical Society of New Jersey.

*Income Ceilings:*

This is the most controversial factor involved in service-indemnity plans. Naturally the practicing physician does not want the income ceiling higher than is consistent with the "service fee" paid by the Plan. He does not want to reduce his fee for services rendered those who ordinarily pay his full fee. This is logical and a line of reasoning which is understandable and acceptable by most reasonable people. Income is not the only factor which determines the ability of a patient to pay for medical care. Other factors, such as the number of dependents, other current indebtedness, place of abode in rural or urban areas and many other factors have led to the adoption of the sliding scale adopted by most physicians. On the other hand, many people, particularly laymen, see no justification or merit in any income ceiling and argue that if physicians receive a reasonable fee for services rendered all people, it makes little difference if occasionally a higher income person receives his care under the Plan on a service basis. They point out particularly that any income ceiling will hinder adequate enrollment in groups of persons with different income levels, and this is true in our experience, since it frequently occurs that those with incomes above the full service ceiling will influence the lower income persons not to sign up.

A sincere effort is being made by service-indemnity plans to be fair to both physician and patient. The best solution so far evolved is to adjust the subscription rate and benefits of the Plan to the income level stated in the contract, allowing for payment by higher income persons of any difference between the

payment of the plan and the fee agreed upon between physician and patient.

*Medical-Surgical Plan of New Jersey:*

Medical-Surgical Plan is an example of the service-indemnity type of plan. During the first ten months of 1945 its enrollment has increased from 30,427 to 48,864 persons and during this period it has paid $177,438.36 to physicians as benefits for services rendered its subscribers and their dependents. The Plan is a successful answer to the problem. Its occasional lack of success is caused by the lassitude of the profession and the people concerning the necessity for solving this problem on a truly democratic basis rather than referring it to government for a solution which we know will not be satisfactory.

## PUBLIC RELATIONS

Organized medicine can learn something about public relations from industry. We can apply some of their techniques.

The best public relations man in industry is the salesman. The good salesman sells his product honestly. He also sells the organization he represents on a basis of its integrity and its product.

The best public relations men in organized medicine are the private practitioners. If they practice honest medicine and express their honest, substantiated opinion during this critical period, they, as individuals, can guide public opinion in favor of organized medicine more effectively than any organized group.

The future of medicine depends upon the attitude and activities of the private practitioners of medicine. If the private practitioner assumes an attitude of indifference or a quiet confidence in our superiority in the belief that the rest of the world believes in our superiority, he is practicing poor salesmanship and poor public relations. Many of our citizens, despite their respect for their family physician, lack faith in organized medicine and in the superiority of the profession in determining the future medical needs of our people. The public must be convinced of our superiority.

Remember, it is public opinion, not the opinion of the medical profession that determines national policies.

## RETURN OF DOCTORS FROM THE ARMED FORCES

Coincident with the announcement of Secretary of War Patterson that an immediate investigation would be made into the need for doctors now in the Army, Major Gen. Norman T. Kirk, Surgeon General of the Army, announced that the Army expects to discharge all but 11,000 doctors by next June. General Kirk said that keeping doctors in service now is required by the fact that there will be some 220,000 patients still in U. S. Army hospitals as of January 1. By that date he expects that some 14,000 doctors, which is more than one-third the number of doctors in the Army Medical Corps at peak strength, will have returned to civilian practice. Army medical officers will continue to be released under previously announced standards, but a further announcement concerning them will be forthcoming around mid-December. — J. A. M. A.

# ORIGINAL ARTICLES

## STREPTOCOCCUS-STAPHYLOCOCCUS COMBINED ANTIGENS IN TREATMENT OF RHEUMATOID ARTHRITIS

### (STREPTOCOCCUS TOXIN — BACTERIAL SUSPENSION) WITH (STAPHYLOCOCCUS TOXOID — BACTERIAL SUSPENSION)

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One of the greatest medical problems of civilization is that of rheumatoid arthritis. It produces disability in patients to such an extent as to expose them to economic trials of unemployment, and the crippling effect makes them reluctant to be active socially and otherwise.

Rheumatoid arthritis may affect persons of any age, but seems to show an apparent preference for the middle aged. Statistically, it has been found that the disease is more common in people between 20 and 50 years, with the incidence being more frequent among females than males.

The disease process of rheumatoid arthritis in most patients may run an active course of some months or even years, then become quiescent. It usually begins as a proliferative synovitis, but soon affects other articular and periarticular tissues. A differentiation between rheumatoid arthritis and osteo-arthritis is of importance. The terminal phalanges are commonly affected in osteo-arthritis, rarely in rheumatoid arthritis. Muscle atrophy, spasms, and ankyloses occur in rheumatoid arthritis, but are not found in osteo-arthritis. Findings such as loss of weight, fatigue, high sedimentation rate, and hypochromic anemia, which are characteristic in rheumatoid arthritis, are not found in osteo-arthritis.

### ETIOLOGY OF RHEUMATOID ARTHRITIS

*Streptococcus:* The etiology of rheumatoid arthritis still remains a major problem. Considerable literature has appeared which stresses the relationship of streptococci to rheumatoid arthritis. The incidence of hemolytic streptococci in the tonsils of patients with rheumatoid arthritis was pointed out by Davis.[1] Streptococci, from enlarged lymph nodes of patients with arthritis, were recovered by Rosenow.[2]

The successful cultivation of streptococci from the blood and joints of arthritic patients was reported by a number of investigators.[3, 4, 5] Cecil et al.[6] recovered streptococci from the blood of 96 patients or 62.3 per cent in a series of 154 cases of rheumatoid arthritis, while in 49 cases in which joint cultures were taken, 35 or 67.3 per cent were positive for streptococci.

Nicholls and Stainsby[7] demonstrated the presence of streptococcic agglutinins in rheumatoid arthritis. A number of other investigators[8, 9, 10, 11] have confirmed the presence of such agglutinins in the serum of patients with rheumatoid arthritis.

1. Davis, D. J.: Bacteriological and Experimental Observations on Focal Infections. Arch. Int. Med. 9: 595 (April) 1912.
2. Rosenow, E. C.: Etiology of Arthritis Deformans. Jour. A. M. A. 62: 1146 (April) 1914.
3. Moon, J. H., and Edwards, S. H: Results of Blood Cultures in Rheumatoid Arthritis. Jour. Infect. Dis. 21: 154 (Aug.) 1917.
4. Gray, J. W., and Gowen, C. H.: Role of Streptococcus in Arthritis deformans; improved cultural method. Amer. Jour. Med. Sci. 182: 682 (Nov.) 1931.
5. Wetherby, M., and Clawson, B. J.: Chronic Arthritis with Special Reference to Intravenous Vaccine Therapy. Arch. Int. Med. 49: 393 (Feb.) 1932.
6. Cecil, R. L.; Nicholls, E. E., and Stainsby, W. J.: The Bacteriology of the Blood and Joints in Chronic Infectious Arthritis. Arch. Int. Med. 43: 571 (May) 1929.
7. Nicholls, E. E., and Stainsby, W. J.: Streptococcal Agglutinins in Chronic Infectious Arthritis. J. Clin. Investigation. 10: 323 (June) 1931.
8. Dawson, M. H.; Olmstead, M., and Boots, R. H.: Agglutination Reactions in Rheumatoid Arthritis. Jour. Immunol. 23: 187 (Sept.) 1932.
9. Gray, J. W.; Fendrick, E., and Gowen, C. H.: Rheumatic Fever and Rheumatoid Arthritis from the Laboratory Point of View. Texas State Jour. Med. 28: 317 (Sept.) 1932.
10. Clawson, B. J.; Wetherby, M.; Hilbert, E. H., and Hilleboe, H. E.: Streptococcic Agglutination in Chronic Arthritis and Acute Rheumatic Fever. Amer. Jour. Med. Sci. 184: 758 (Dec.) 1932.
11. Keefer, C. S.; Myers, W. K., and Oppel, T. W.: Streptococcal Agglutinins in Patients with Rheumatoid (atrophic) Arthritis and Acute Rheumatic Fever. Jour. Clin. Investigation, 12: 267 (March) 1933.

In contrast to the evidence of investigators who have demonstrated a close relationship between streptococci and rheumatoid arthritis is the evidence submitted by those who were not able to obtain the same results under apparently identical conditions.[12, 13, 14]

Angevine, Rothbard and Cecil[15] reported that in their recent investigations no organisms of significance had been successfully isolated either from rheumatoid arthritis or rheumatic fever.

*Foci of Infection:* A concept exists that metastatic infection of joints from foci of infection constitutes the sole basis for joint lesions. As Pelouze[16] so well states: "The outstanding focal infection triad in the male is teeth, tonsils and prostate gland." The doctrine of focal infection and the accepted rôle of bacteria with the existence of a relationship of elective affinity has been presented by Rosenow;[17] Nakamura[18] and substantiated by Haden.[19].

Evidence has been submitted by Pringle and Miller[20] to support their belief that focal infection exists in all arthritics who present a delayed sugar removal. They confirmed the fact "that delayed sugar removal in arthritis tended to return to normal when foci were removed or upon recovery from arthritis. The return to normal seemed to occur more rapidly after surgical removal of the causative infection."

*Diet:* The important rôle of diet in rheumatoid arthritis cannot be ignored. It is well established that chronic dietary deficiencies may so affect the physiological mechanisms as to permit bacteria to become more immediate factors in a given disease.

Clausen[21] reached the conclusion that resistance to infection may be greatly reduced by a deficient diet. It was observed by Cramer[22] that non-virulent organisms became pathogenic in animals on diets deficient in vitamins A and C. Rinehart[23] reported finding joint lesions comparable to those of rheumatoid arthritis in vitamin C deficient animals inoculated with virulent streptococci.

*Comment:* The weight of evidence seems to support the streptococcal rôle in the etiology of rheumatoid arthritis. To substantiate this, the microscopic picture is definitely that of an infectious process. It is not the purpose of this report to subscribe to the belief that the streptococcus is the sole etiologic factor. Nevertheless, it is our opinion that, if not the streptococcus itself, then its toxins and toxic products are contributing factors to the pathology manifested in rheumatoid arthritis. We are of the opinion that in the early stages of arthritis, there exists a disturbance in the physiological process, which, in all probabilities, is largely of a functional nature, permitting the deleterious actions of the infective processes to manifest themselves in organic changes.

The existence of a close relationship between blood circulation, focal infection and sugar tolerance can be readily demonstrated. A denial to the muscular tissues of their usual degree of contact with circulating blood interferes with the withdrawal of glucose, so that where sugar is fed, a lowered tolerance results. This clearly suggests that circulatory changes plus focal infection, with which lowered sugar tolerance is closely allied, contribute to the pathology of arthritis.

## RHEUMATOID ARTHRITIS AND RHEUMATIC FEVER

The existence of a close relationship between rheumatoid arthritis and rheumatic fever is supported by the evidence presented by many investigators.

12. Dawson, M. H.; Olmstead, M., and Boots, R. H.: Bacteriologic Investigation on Blood Synovial Fluid and Subcutaneous Nodule in Rbeumatoid (Chronic) Infectious Arthritis. Arch. Int. Med. 49: 173 (Feb.) 1932.
13. Key, J. A.; Personal Futile Attempts to Prove Infectious Origin of Chronic Arthritis. South. Med. Jour. 26: 1059 (Dec.) 1933.
14. Wainwright, C. W.: The Treatment of Chronic Arthritis with Streptococcus Vaccine. Jour. A. M. A. 103: 1357 (Nov.) 1934.
15. Angevine, M. D.; Rothbard, S., and Cecil, R. L.: Cultural Studies in Rbeumatoid Arthritis and Rheumatic Fever. Amer. Rheumatic Dis. 3 (2): 101 (Dec.) 1942.
16. Pelouze, P .S.: Cited by R. Pemberton in "Artbritis and Rheumatoid Conditions." Lea and Febiger, Phila., page 219: 1935.
17. Rosenow, E. C.: The Relation of Dental Infection to Systemic Disease. Dental Cosmos 59: 485 (June) 1917.
18. Nakamura, T.: A Study of Focal Infection and Elective Localization in Ulcer of Stomach and in Arthritis. Ann. of Surgery, 79: 29 (Jan.) 1924.
19. Haden, R.: Elective Localization of Streptococci. South. Med. Jour. 19: 253 (April) 1926.
20. Pringle, G. L. K., and Miller, S.: Glucose Tolerance in Chronic Arthritis and Allied Conditions. Lancet 1: 171 (Jan.) 1923.
21. Clausen, S. W.: The Influence of Nutrition upon Resistance to Infection. Physiol. Rev. 4: 309 (July) 1934.
22. Cramer, W.: Vitamins and Borderline Between Health and Disease. Lancet 1: 633 (Marcb) 1924.
23. Rinehart, J. F.: Cited by Cecil, R. L.: Medical Treatment of Chronic Arthritis. Jour. A. M. A. 103: 1587 (Nov.) 1934.

*Subcutaneous Nodules:* A strong argument for this relationship, according to McEwen,[24] is the similarity of the subcutaneous nodules in the two diseases. Dawson[25] stated: "If one studies nodules which have persisted for many months in rheumatic fever, one will find them surprisingly similar to nodules of corresponding duration in rheumatoid arthritis."

*Autopsy Evidence:* Smyth,[26] commenting on the autopsy findings in 10 rheumatoid arthritis patients, stated: "The occurrence of this high percentage of lesions characteristic of rheumatic heart disease is strong evidence to indicate that rheumatoid arthritis and rheumatic fever are related." Young and Schwedel[27] in a report on the post-mortem and clinical data on 38 adults with rheumatoid arthritis stated: "The extremely high incidence of rheumatic heart disease in this and previous pathologic studies suggests an extremely close relationship which should lead to consideration of the possibility that they may be manifestations of the same underlying disease process."

*Etiology in Rheumatic Fever:* Sufficient evidence exists to indicate that a persistence or recurrence of rheumatic activity is related to a persistence or recurrence of the precipitating bacterial activity.

The close etiologic relationship between the beta-hemolytic streptococcus and rheumatic fever has become more and more apparent. As Paul[28] stated: "It is safe to say that there have been no records of epidemics without preceding epidemics of hemolytic streptococcus infection." Jones[29] observed that bacteriologic findings and the result of immunologic tests indicate a close association between rheumatic fever and preceding respiratory infection with beta-hemolytic streptococci. Among trainees studied by Green,[30] the only infection which led to the appearance of rheumatic fever was hemolytic streptococcal infection.

As observed by Kuttner,[31] the relationship between streptococcal pharyngitis and the reactivation of the rheumatic process is specific, and the importance of group A hemolytic streptococci as a factor in the etiology of rheumatic fever is established.

*Comment:* The emphasis placed on the probability that the streptococcus is the etiologic factor in rheumatic fever does not indicate this has been definitely proven. The streptococcus apparently does have some part in the disease process, but further proof is necessary to show it to be the sole cause of rheumatic fever.

If the similarity between rheumatoid arthritis and rheumatic fever does exist as reported, and the streptococcal rôle in the etiology of rheumatic fever is established, then it might be that the streptococcus plays some rôle in the etiology of rheumatoid arthritis.

If the streptococcus is not of itself the cause, it is probable that toxins and toxic products produced by the streptococci at the site of a focus of infection may have a special affinity for synovial membranes, resulting in chronic irritation and eventually in the joint changes. The affinity of toxins and toxic products of specific bacteria for certain special sites in the body is an established fact, and it may well be applied in the case of rheumatoid arthritis.

## VACCINE THERAPY

There apparently is as much divergence of opinion relative to the merits of vaccine therapy in rheumatoid arthritis, as there is in the etiology of this condition.

Cecil et al.[6] concluded that a vaccine prepared of typical strains of bacteria cultured from the blood and joints of patients with rheumatoid arthritis, was of considerable value in many cases. Marvin[32] observed that streptococcus vaccines administered intravenously were most beneficial as a supplement to other forms of treatment. Clawson and Wetherby[33] reported clinical improvement in about 80 per

24. McEwen, C.: Discussion: Proceedings Amer. Rheum. Assoc. Annals Int. Med. 19: 115 (July) 1943.
25. Dawson, M. H.: Proceedings of Amer. Rheum. Assoc. Annals Int. Med. 19: 115 (July) 1943.
26. Smyth, C. J.: Proceedings of Amer. Rheum. Assoc. Annals Int. Med. 19: 117 (July) 1943.
27. Young, D., and Schwedel, J. B.: Heart in Rheumatoid Arthritis: Study of 38 Autopsy Cases. Amer. Heart Jour. 28: 1-32 (July) 1944.
28. Paul, J. R.: Abstract of Discussion: Discussion on Rheumatic Fever. Jour. A. M. A. 126: 493 (Oct. 21) 1944.
29. Jones, T. D.: The Diagnosis of Rheumatic Fever. Jour. A. M. A. 126: 481 (Oct. 21) 1944.
30. Green, C. A.: Acute Rheumatism in the Recruit. M. Press. 205: 523 (June) 1941.
31. Kuttner, A. G.: Discussion: Proceedings of Amer. Rheumatism Assoc. Annal. Int. Med. 19: 110 (July) 1943.
32. Marvin, Capt. H. P.: The Value of Intravenous Vaccine Therapy in Arthritis. Military Surgeon, 73: 74 (August) 1933.
33. Clawson, B. J., and Wetherby, M.: An Experimental Basis for Intravenous Vaccine Therapy in Chronic Arthritis with a Summary of Results Obtained in Patients. Annal. Int. Med. 5: 1447 (Nov.) 1932.

cent of patients who received five or more intravenous injections of a streptococcus vaccine. Rawls et al.[34] found that small, repeated intravenous doses of streptococcus vaccine tended to desensitize the patient. Marked improvement was reported by Moon and Edwards[3] in cases of arthritis of various types treated with autogenous vaccine combined with other therapeutic measures.

Swift et al.,[35] and Wilson and Swift[36] suggested that immunizing process in cases of rheumatic fever, could probably be accelerated and a state of resistance induced in patients who otherwise were incapable of spontaneously developing it. It was thought this might be accomplished by the intravenous injection of streptococci or their products. As a result of their observations, they suggested that further investigations are warranted, especially in two types of patients: (1) those with continuing low grade infections, and (2) those temporarily free from symptoms, but in whom relapses may be reasonably expected.

By using a hemolytic streptococcus filtrate, Wasson[37] and Wasson and Brown[38] apparently benefited rheumatic fever patients, as they reported more than four times as many attacks among controls as in treated patients.

In rebuttal to the effective clinical results obtained in rheumatoid arthritis patients by the use of vaccine are the reports of those investigators who present findings which are not promising. Short and Bauer[39] concluded: "There is neither clinical or theoretical ground for the use of vaccine in rheumatoid arthritis. There is no objection to their use in patients who are doing badly or standing still." Margolis and Eisenstein[40] expressed the opinion that undoubted clinical improvement attributable to vaccine therapy is rarely observed.

Intravenous injections with streptococcal vaccines in the treatment and prophylaxis of rheumatic fever were tried by Wilson et al.[41] and Coburn and Pauli.[42] They were unable to demonstrate any increased resistance to streptococcic infection or rheumatic recrudescences.

*Comment:* In the treatment of rheumatoid arthritis, additional therapeutic measures along with vaccine therapy are necessary for effective clinical results.

A number of factors which would influence good response to vaccine therapy should be given consideration. The cultures used in the preparation of the vaccines should be obtained from suitable foci of infection, and the antigen prepared by special and adequate treatment. We have found that success in obtaining effective antigens depends on the selection of the proper colonies for use in preparing the finished product. The colonies should demonstrate satisfactory toxignomic properties, and should possess suitable antigenic properties. Proper incubation temperature and the period of incubation are of extreme importance. Improper handling tends to produce a vaccine in which the antigenic characteristics are unsatisfactory.

A number of investigators[43, 44, 45, 46] reported better immunological response to a combination of a vaccine and a toxoid than had been possible to obtain with either one alone.

### PREPARATION OF STREPTOCOCCUS-STAPHYLOCOCCUS COMBINED ANTIGENS

The cultures used in the preparation of the streptococcus-staphylococcus combined antigen

34. Rawls, W. S.; Greeskin, B. J., and Ressa, A.: Intravenous Vaccine Therapy in Chronic Arthritis. Annal Int. Med. 7: 566 (Nov.) 1933.
35. Swift, H. F.; Hitchcock, C. H.; Derick, C. L., and McEwen, C.: Intravenous Vaccination with Streptococci in Rheumatic Fever. Amer. Jour. Med. Sci. 181: 1 (Jan.) 1931.
36. Wilson, M. G., and Swift, H. F.: Intravenous Vaccination with Hemolytic Streptococci: Its Influence on Incidence of Recurrence of Rheumatic Fever in Children. Amer. Jour. Dis. Child. 42: 42 (July) 1931.
37. Wasson, V. P.: Immunization Against Rheumatic Fever with Hemolytic Streptococcus Filtrate. Amer. Heart Jour. 15: 257 (March) 1938.
38. Wasson, V. P., and Brown, E. E.: Immunization Against Rheumatic Fever with Hemolytic Streptococcus Filtrate. Amer. Heart Jour. 20: 1 (July) 1940. Ibid. 23: 291 (March) 1942.
39. Short, C. L., and Bauer, W.: The Treatment of Rheumatoid Arthritis. New Eng. Jour. Med. 227: 442 (Sept.) 1942.
40. Margolis, M. H., and Eisenstein, W. V.: Some Specific Measures in the Treatment of Rheumatoid Arthritis. Jour. A. M. A. 114: 1929 (April) 1940.
41. Wilson, M. G.; Josephi, M. G., and Lang, D. M.: Intravenous Vaccination with Streptococci: Its Influence on Incidence of Recurrence of Rheumatic Fever in Children. Amer. Jour. Dis. Child. 46: 1329 (Dec.) 1933.
42. Coburn, A. F., and Pauli, R. H.: Studies on Immune Response of Rheumatic Subject and Its Relationship to Activity of Rheumatic Process. Jour. Clin. Investigation 14: 763 (Nov.) 1933.
43. Ramon, G., and Zoeller, C.: Les "vaccins associes" par union d'une anatoxine et d'un vaccin meroben (TAB) ou par melanges d'anatoxines. Compt. Rend. Soc. de biol. 94: 106 (Jan. 22) 1926.
44. Maclean, I. H., and Holt, L. B.: Combined Immunization with Tetanus Toxoid and T. A. B. Lancet 2: 581 (Nov. 9) 1940.
45. Goodman, M. H.: Combined Vaccine and Toxoid Therapy of Staphylococcic Infections of the Skin. Arch. Derm. and Syph. 47: 640 (May) 1943.
46. Jordan, M. Charlotte: Staphylococcal Vaccine-Toxoid Combined in the Treatment of Acne. Urologic and Cutaneous Review, 47: 185 (March) 1940.

used in this study were obtained from teeth, tonsils, urine and feces of rheumatoid arthritis patients. Only those cultures were selected which met our requirements.

The bacteria selected were of smooth colony type and found to be broadly antigenic. They were grown in the usual manner on solid medium, washed from the surface of the medium at the end of the incubation period with sterile saline solution and the count per cc. determined.

The streptococcus and staphylococcus toxins were produced in the usual manner in suitable fluid medium and tested by means of intradermal injections into susceptible animals, for the minimum necrotizing dose in the case of the staphylococcus toxin, and skin test in the case of the streptococcus toxin.

The staphylococcus toxin was converted to a toxoid by means of formaldehyde and incubation at 37° C. The streptococcus toxin was purified by means of ammonium sulfate precipitation, then precipitated with tannic acid after the method of Veldee [47] and washed.

The two bacterial suspensions and the staphylococcus toxoid were pooled in appropriate proportions; the mixture precipitated with potash alum, washed several times with sterile saline solution, then finally brought back to original volume with sterile saline containing a preservative. To this mixture was added the requisite quantity of precipitated streptococcus toxin to make the following antigen:

| | |
|---|---|
| Staphylococcus aureus | 1000 M./cc. |
| Staphylococcus toxoid | 500 M.N.D./cc. |
| Streptococcus (hemolytic-non-hemolytic and viridans) | 2000 M./cc. |
| Streptococcus toxin (tannic acid pp'td.) | 1000 S.T.D./cc. |

## SELECTION OF PATIENTS

Thirty-four patients selected for this study were on other types of therapy, such as: gold, sulfur, foreign proteins, blood irradiation, ertron, salicylates, autogenous vaccines and hormone preparations, for periods ranging from six months to many years. Their condition was getting either progressively worse or was at a standstill. The number of males and females, their average age and average duration of arthritis are given in table 1.

TABLE 1

| | Females | Males |
|---|---|---|
| No. of patients | 27 | 7 |
| Average age of patients | 55.14 years | 41.4 years |
| Average age at onset | 47.2 years | 33.5 years |
| Average duration of arthritis | 7.85 years | 7.78 years |

It was observed that a greater incidence of rheumatoid arthritis prevailed in the later years of life in females as compared to males. This observation is given in table 2.

## PROCEDURE OF TREATMENT

After a complete history had been taken, each patient was given a thorough physical examination. X-rays of affected joints were ordered, and complete blood count and sedimentation rate were requested prior to therapy.

In the treatment of rheumatoid arthritis, additional therapeutic measures in addition to the combined antigen therapy, were deemed essential in order that the clinical results might be favorable.

There is no doubt but that the success of any therapy depends to a large extent on the condition of the patient. In our procedure, investigations were made for nutritional deficiencies; liver dysfunction, which is known to produce an excessive toxic load, and possible endocrine disturbances. When any of these conditions existed, supplemental therapy was prescribed.

47. Veldee, M. V.: Tannic Acid Precipitation of Scarlet Fever Toxin. Public Health Report 53: 909 (June 3) 1938.

TABLE 2

| Between Ages | Females | Average Duration of Arthritis | Males | Average Duration of Arthritis |
|---|---|---|---|---|
| 20-30 | 0 | 0 | 2 | 5.5 years |
| 30-40 | 2 | 9 months | 2 | 4 years |
| 40-50 | 7 | 9.28 years | 1 | 12 years |
| 50-60 | 7 | 4.57 years | 1 | 9 years |
| 60-70 | 8 | 7.87 years | 1 | 15 years |
| 70-80 | 3 | 16.8 years | 0 | 0 years |

That rest plays an important rôle in the treatment of rheumatoid arthritis is well established, and this therapeutic measure was strongly stressed. Proper diet, and the need for regularity in elimination were advocated. Whenever supplemental measures in the form of vitamins or iron were indicated, these were prescribed.

Sufficient time was given at each visit to each patient, so as to impress him with the fact that we were vitally interested in his condition and problems. Our first concern was to improve the mental attitude of each patient, which, in our opinion, is a "must" in the therapeutic regimen of an arthritis patient.

*Streptococcus-Staphylococcus Combined Antigen Treatment:* The combined antigen was given deep intramuscularly in either the deltoid or gluteal region at weekly intervals. The initial dose was 0.1 cc., increased by increments of 0.2 cc. until 1.0 cc. was given. After the maximum dose of 1.0 cc. was reached, the patients were given this dose for an average of six injections at weekly intervals, then at two-week intervals. In some patients the dose was reduced, so that 0.5 cc. to 0.8 cc. was arrived at as the maintenance dose given at two-week intervals, with an occasional rest period of three to four weeks.

*Reactions:* In some patients it was necessary to proceed more slowly in increasing the doses because of local reactions. Only occasionally were systemic reactions reported; these occurring more frequently in the less chronic cases.

There were three patients in whom the arthritic symptoms were apparently exacerbated by the injection of 1.0 cc. doses of the combined antigen. Although the sedimentation rate did not increase, it nevertheless continued at a high level. The doses in these patients was reduced to 0.5 cc. and given every two weeks rather than weekly. This change in procedure resulted in a rapid improvement of the patients; two patients after the fourth reduced dose, and the third after the sixth reduced dose.

One of the patients (M. H.) showed slow improvement. Though she was gradually improving, it was not comparable to that in other patients in her group. The 25th injection of the antigen was given in the gluteal region, and resulted in a large localized abscess. She experienced chills and fever until the abscess was incised and drained. No injections were given until the abscess was completely healed; after which she was started on one-half of her maximum dose at two-week intervals. Her improvement and progress were beyond expectations.

### CRITERION FOR MEASURING IMPROVEMENT

The criterion used for measuring improvement in the treated patients was as follows: (1) relief of pain in the affected joints; (2) improved sense of well being; (3) improved function of affected joints; (4) diminution of soft tissue swelling, and (5) ability to resume work, which, naturally indicated improved muscular strength.

The average time in which improvement was manifested in the patients of each group is given in tables 3 and 4.

A study of table 3 shows that the older patients in the final group reported improvement much sooner than did the younger patients. Chronicity of the arthritic apparently had no influence on the rate of response or the degree of improvement. In fact, the statistics show that the response was much quicker in those patients who reported arthritis of longer duration than in those who reported a shorter duration.

*Results:* The clinical results as observed in the thirty-four patients in this report are tabulated in table 5. Sixteen patients were able to resume normal activities; ten were considerably benefited and eight were only slightly improved or not at all. Of the eight patients, two did not continue with the treatment long enough to warrant any definite conclusion.

TABLE 3

FEMALES

| Patient | Age | Diagnosis | Duration | Reported Improvement |
|---|---|---|---|---|
| A. H. | 34 | Rheumatoid | 6 months | 8 weeks |
| A. S. | 38 | Rheumatoid | 1 year | 7 weeks |
| M. H. | 41 | Adv. Rheumatoid | 20 years | 14 weeks |
| H. A. | 41 | Adv. Rheumatoid | 11 years | 4 weeks |
| A. B. | 42 | Early Rheumatoid | 4 years | 7 weeks |
| C. F. | 43 | Adv. Rheumatoid | 3 years | 4 weeks |
| M. M. | 46 | Rheumatoid | 6 years | 4 weeks |
| E. S. | 46 | Rheumatoid with osteo | 16 years | 8 weeks |
| G. W. | 48 | Osteo-subdelt. bursitis | 5 years | Taken off—no improvement |
| B. S. | 50 | Osteo. with Rheumatoid | 2 years | 5 weeks |
| E. Mc. | 52 | Rheumatoid | 5 years | 3 weeks |
| M. L. | 53 | Acute Adv. Rheumatoid Recurring | 2 years | 8 weeks |
| M. G. | 54 | Adv. Rheumatoid | 4 years | 4 weeks |
| J. H. | 55 | Rheumatoid | 10 years | 6 weeks |
| K. B. | 57 | Rheumatoid | 4 years | 4 weeks |
| E. Q. | 58 | Rheumatoid | 5 years | 4 weeks |
| A. B. | 60 | Rheumatoid with osteo | 2 years | No improvement after 22 weeks |
| A. P. | 61 | Fibrositis | 2 years | 6 weeks |
| L. M. | 61 | Rheumatoid | 15 years | 4 weeks |
| R. W. | 62 | Predominating Rheumatoid with osteo | 2 years | 8 weeks |
| M. G. | 64 | Rheumatoid | 11 years | 3 weeks. Discontinued clinic after 4 injections |
| M. R. | 66 | Rheumatoid | 20 years | 4 weeks |
| V. S. | 68 | Rheumatoid | 5 years | 4 weeks |
| L. H. | 69 | Rheumatoid | 6 years | 3 weeks |
| D. L. | 70 | Rheumatoid | 10 years | Does not attend clinic regularly |
| P. G. | 75 | Rheumatoid with osteo | 40 years | 6 weeks |
| A. C. | 75 | Mod. Rheumatoid | 6 months | 4 weeks |

TABLE 4

MALES

| Patient | Age | Diagnosis | Duration | Reported Improvement |
|---|---|---|---|---|
| P. B. | 24 | Early Rheumatoid | 6 months | 8 weeks |
| L. T. | 29 | Rheumatoid | 10 years | 5 weeks |
| M. G. | 37 | Fibrositis | 6 years | 4 weeks |
| R. D. | 37 | Early Rheumatoid | 2 years | 4 weeks |
| J. P. | 40 | Adv. Rheumatoid | 12 years | 5 weeks |
| J. M. | 58 | Osteo-Spondylitis-Subdeltoid bursitis | 9 years | 11 weeks |
| G. W. | 65 | Rheumatoid with osteo. | 15 years | 12 weeks |

TABLE 5

| | |
|---|---|
| Were able to resume normal activity | |
| Females, 11; males 5 | 47.06% |
| Showed improvement in that their pains were controlled, swellings were reduced, and were able to do a moderate amount of work: | |
| Females, 8; males 2 | 29.41% |
| Showed only moderate improvement or none at all: | |
| Females 8 * | 23.53% |

* Includes two patients who stopped coming to the clinic—although somewhat improved.

CASE REPORTS

Since space does not permit the presentation of all the cases treated, we have chosen three which are of greater interest:

1. J. P., male, 40, with rheumatoid arthritis of twelve years' duration, had been on various types of therapy without any apparent benefit. He had sulfur, intravenously and orally, blood irradiation, and gold. This patient could not tolerate the gold treatment.

When he presented himself for the combined antigen treatment, he could not raise his arms to tie his cravat or to comb his hair. The fingers were doughy, swollen, the elbows and knees the same. He complained of severe pains throughout his body and could not work.

This patient was started with an 0.1 cc. dose given deep intramuscularly in the deltoid region. The following week he received 0.3 cc., then 0.5 cc. The injections were given at weekly intervals. After the fourth dose, which was 0.6 cc., the patient was able to use his hands, bend his elbow, and the swellings in his joints were considerably reduced. From this point on the patient continued to improve, and was able to go back to his work, which

of course, had to be limited. He is now being carried along on an 0.8 cc. dose which will continue to be given at weekly intervals until he has received at least twelve such doses, after which the injections will be spaced further apart, and finally discontinued.

2. M. G., female, 54, with rheumatoid arthritis, of four years' duration, had been treated with glycerinated sulfur and gold. She received a full course of each of these without any apparent benefit.

At the time she was started on the combined antigen treatment, she could not close her hands, nor could she bend her arms. There was no doubt that she was getting progressively worse.

This patient was started June 3, 1943, with an 0.1 cc. dose which produced local and systemic reactions of mild proportions. The doses were stepped up by 0.1 cc. each week, and at the seventh injection, which was the 0.8 cc. dose, she reported marked improvement. The swelling of the joints was considerably reduced, and she had moderately good function of her hands and elbows. At the thirty-seventh injection, the patient was given a rest period of two months. She felt so good that she took a motor trip to Wisconsin and returned, without any aggravation of her former symptoms. This patient is now on a maintenance dose of 0.7 cc. given at two-week intervals.

3. R. W., female, 62, predominating rheumatoid with osteo-arthritis of two years' duration, involving fingers, hands and knees. This patient had been started on gold therapy July 2, 1942, and continued on gold until May 13, 1943. Treatment with combined antigen was started February 19, 1944. The initial dose was 0.2 cc. and on the sixth injection she received 1.0 cc. The injection given at weekly intervals. Occasional local reactions occurred but none were so severe as to cause undue discomfort. After the fourteenth weekly injection, the patient was treated every two weeks with her maximum dose of 1.0 cc. Improvement in her condition was manifested on the fourth injection. The patient has returned to work, and is able to use her hands efficiently in the type of work she is doing.

## SUMMARY AND COMMENTS

Thirty-four patients with rheumatoid arthritis, comprising 27 females and 7 males, were treated with a streptococcus-staphylococcus combined antigen (streptococcus toxin-bacterial suspension combined with staphylococcus toxoid-bacterial suspension). This therapy was used in combination with other therapeutic measures, such as, rest, diet, and supplemental therapy when indicated. Each patient was given individual attention; physical examination made; x-rays and laboratory reports obtained; and the condition and prognosis thoroughly discussed.

The clinical results obtained are gratifying and indicate that a further study of the value of streptococcus-staphylococcus combined antigen as a therapeutic agent in rheumatoid arthritis is warranted. Of the 34 patients treated, 47.06 per cent were able to resume normal activity; 29.41 per cent showed improvement in that their pains were controlled, swellings reduced, and were able to resume limited activities; 23.5 per cent showed only moderate improvement or none at all.

It was observed that when the dose of the streptococcus-staphylococcus combined antigen was increased according to schedule in some patients, their arthritic symptoms were exacerbated, and the sedimentation rate continued at a high level. This, we found, did not warrant discontinuing the treatment, since a reduction in the dose to one-half, and a spacing of the injections further apart, resulted in a marked improvement in the patients in a relatively short time. We will comment on this in more detail in a complete report of this investigation to be submitted at a later date.

We are continuing with the investigation of this therapy in the treatment of rheumatoid arthritis so that our findings may be confirmed.

N.B. The streptococcus toxin-bacterial suspension with staphylococcus toxoid-bacterial suspension was supplied by the Biological Research Laboratories of The National Drug Company, Philadelphia, Pa.

717 West State Street, Trenton, New Jersey

528 Washington Street, Allentown, Pensylvania

# REDUCING THE PERIOD OF POST-OPERATIVE BEDREST

R. T. deHellebranth, M.D., Ventnor, N. J.

In the surgical wards one often encounters patients who get out of bed before they are permitted to do so, either because they are uncoöperative by nature, or because opiates and barbiturates have a stimulating effect on them. They sometimes do so soon after their operations, even during the first post-operative night, and one is surprised to find that these patients seldom suffer ill effects, nor do children or infants have wound disruptions, although they all but turn sommersaults after operations.

These facts, and many others such as the scarcity of nurses, etc., gave us the impulse to permit patients to get out of bed much sooner than the customary eighth or tenth day, which is usually after their wound clips and sutures have been removed. The idea, of course, is not new, some surgeons having long ago permitted patients to walk back to their rooms following herniotomies, for instance, carried out under local anesthesia. This article, therefore, is only an attempt to show the results of the newly adopted routine which was employed in a hundred and thirty unselected cases in the course of five months.

The cases were as follows:

| | |
|---|---|
| One-stage abdomino-perineal resection for carcinoma of the rectum | 1 |
| Cholecystectomy | 15 |
| Subtotal thyreoidectomy (for hyperthyreoidism) | 5 |
| Appendectomy (McBurney incision) | 6 |
| " (Right paramedian incision) | 11 |
| Prostatectomy (two stage; after each operation) | 3 |
| Partial gastrectomy | 2 |
| Hysterectomy (total) | 12 |
| " (subtotal) | 19 |
| " (vaginal) | 3 |
| Ligation of superficial femoral artery for aneurysm | 1 |
| Herniotomy (bilateral) | 9 |
| " (unilateral) | 12 |
| " (recurrent with fascial graft) | 9 |
| Excision of extensive varicosities (one leg) | 3 |
| (both legs) | 3 |
| Hemorrhoidectomy | 10 |
| Radical mastectomy | 4 |
| Splenectomy | 1 |
| Pilonidal sinus | 1 |

The patients who were permitted up the earliest were those with herniotomies, and appendectomies with McBurney incisions. These were permitted to sit in an armchair on the first post-operative day. So were patients following hemorrhoidectomy, excision of pilonidal sinus, and excision of extensive varicosities. Patients with thyreoidectomy or appendectomy through a paramedian incision were gotten up on the second post-operative day. Mastectomies, and some laparotomies, including cholecystectomy with drainage, were permitted to sit in an armchair after they had received their first soapsuds enema; that is, seventy-two hours post-operatively. All these patients were encouraged to walk to the bathroom on the next day with the nurse's help, and later alone. Most patients followed instructions with the greatest willingness. None of them fainted, and almost all of them found the time they were allowed to spend out of bed all too short.

At the beginning patients with a temperature over 99° were kept in bed, but later a temperature of 100° was not considered a contraindication to their getting up.

In the afore-mentioned series there were two complications:

1. Pulmonary infarct: A 56-year-old bartender, a heavy drinker and smoker, with marked coronary sclerosis and a four-plus blood Wassermann reaction, was operated on for a large scrotal hernia. He was permitted to get out of bed on the first post-operative day and on the next day he was walking around without any assistance. On the fifth post-operative day, while returning to bed he suddenly collapsed, became cyanotic and orthopneic, and was covered with cold sweat. He complained of severe pain in the chest and his pulse became imperceptible. Blood pressure reading could not be obtained. Oxygen was administered in high concentration, venoclysis was started with 1000 c.c. of five per cent glucose in physiologic saline solution, containing also 2 c.c. of Coramine and 2 c.c. of Ephedrine

solution, and papaverine and atropin sulphate were given repeatedly. His condition improved in the next four hours, but on the following day he produced bloody sputum and his temperature rose to 101 with a leucocyte count of 14,200, and sedimentation rate of 68 in an hour. Examination revealed the presence of a pulmonary infarct on the right side. His condition improved steadily, and on the tenth post-operative day he was permitted to go home by ambulance. He got out of bed three weeks later, and at the present time he seems to be in good condition.

2. Wound disruption: A 55-year-old woman was operated on for empyema of the gall-bladder. She had been hospitalized two months previously but was sent home because she suffered with a non-productive cough which was due to her incessant smoking. When she did not respond to any treatments, she was re-admitted to the hospital and operation decided upon. It was performed under spinal anesthesia and she was gotten out of bed on the third post-operative day. On the seventh post-operative morning she had a violent coughing spell and soon the ominous bright red blood stains appeared on the dressing. The sutures and clips were removed and there was a five-inch disruption of the incision, through which coils of small intestine protruded. The incision was re-sutured under local anesthesia with several through-and-through silk sutures, and she was permitted to get up on the following day. She was sent home on the twelfth post-operative day but the sutures were not removed until she made a follow-up visit on the twenty-first post-operative day. Her incision healed primarily, and she shows no signs of an incisional hernia.

The author himself got out of bed on the first post-operative morning, after he had undergone an appendectomy the previous afternoon for acute appendicitis with perforation. He went to the bathroom and shaved himself, and did so every morning thereafter. He resumed his active surgical duties three weeks after his own operation. His wound still had not healed at the site of the drains, but he developed no incisional hernia.

One patient was operated on for a recurrent bilateral inguinal hernia with fascia graft. During the first post-operative night, he sent the nurse out for a urinal and in her absence he got up and climbed down the fire-escape. He was found an hour later nonchalantly strolling in the street. His wounds healed primarily, and he had no recurrence of his hernia a year later when he was committed to the state insane asylum.

In the laparotomies no transverse incisions were used, and the wounds were closed in the usual manner: the peritoneum with a continuous 00 chromic catgut, the muscles with interrupted 00 chromic catgut, the aponeurosis or fascia with interrupted 0 chromic catgut, the skin with three mattress sutures and wound clips. No silk sutures were used in the herniotomies or McBurney incisions.

## SUMMARY

Reporting the results of permitting patients to get out of bed early after major operations, in one hundred and thirty cases with two complications which, however, cannot be ascribed to the new practice. The results were very gratifying. The nurses' work was made lighter by their not having to give constant attention to bed-ridden patients, patients were more cheerful and regained their self-confidence shortly after the operation, the post-operative temperature curve was lower, a very small percentage had to be catheterized, and few of them complained of gas pains. Patients were also able to leave the hospital and return to their regular work much earlier than did other patients who had similar operations and were kept in bed for eight to twelve days.

# THE TREATMENT OF ANGINAL SYNDROME WITH THIOURACIL

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Following the report by Astwood[1] on the use of thiouracil in hyperthyroidism, the effectiveness of the drug has been demonstrated by a number of investigators.[2] From animal experiments it is believed that thiouracil exerts a depressant action on the anterior pituitary with a resultant lowering of the thyroid stimulating hormone. It also has a depressant action on the thyroid by interfering with the ionization of the thyroglobulin molecule and the production of the physiologically active thyroid hormone.

In December, 1943, a patient with severe angina pectoris came under observation. The patient had tachycardia, slight tremors and was nervous. The B. M. R. was +24 and an electrocardiogram showed transitory changes during an attack of angina pectoris. She was given thiouracil with remarkable clinical improvement in the angina. Impressed by the striking results, and in view of the fact that beneficial results by thyroidectomy in heart disease have been described by Blumgart, Levine and Berlin,[3] and also by others,[4] it was decided to study the effect of the drug in cases with angina pectoris in which the basal metabolic rates were within normal limits.

## METHOD

During the thirteen months preceding this report, eight patients—seven men and one woman—have been treated with thiouracil for angina pectoris. The diagnosis was based on a history of typical attacks of substernal pain, precipitated by exertion, relieved by rest or nitroglycerine. In two cases there were transitory alterations in the electrocardiogram during an attack of angina indicating that the attacks were caused by transitory coronary insufficiency. In six cases, the electrocardiograms showed changes suggesting the possibility of healed infarctions. Each patient was given 0.6 gm. of thiouracil daily for two weeks, followed by a maintenance dose of 0.2 gm. No other medication was given except nitroglycerine for relief of pain during an attack. The patients were instructed to perform their previous activities if possible, and to report the amount of physical activity necessary to produce an attack, as well as the frequency, duration and severity of the attacks. Blood counts were taken at weekly intervals and later every two weeks. The basal metabolic rate was determined before treatment and at monthly intervals during treatment. The results were classified as excellent when the patient was symptom free; good when mild pain occurred infrequently and on extreme exertion; fair when the limit of activity slightly increased. These results are summarized in Table 1, and a brief history follows:

*Case 1:* F. M., a 54-year-old housewife, had attacks of severe substernal pain during a period of five years. The pain was vise-like in character and radiated to both arms. It was induced by the slightest exertion or emotion, lasted about five minutes and was relieved by nitroglycerine or by rest. She resorted to about 8 to 10 nitroglycerine tablets daily.

On physical examination, the patient appeared nervous. The thyroid gland was not enlarged. There were moderate tremors of the hands. The lower and outermost point of the heart was in the fifth interspace at the midclavicular line. There were no murmurs heard. The blood pressure was 160 systolic and 100 diastolic. The radial pulse was

* The thiouracil was supplied by the Lederle Laboratories, Inc., Pearl River, N. Y.

† Note added June 18, 1945.—Since this article was written, Raab reported ten cases of angina pectoris treated with thiouracil. J. A. M. A., 128, 249, May 26, 1945.

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Clark, R. J.; Means, J. H., and Sprague, H. B.: Total Thyroidectomy for Heart Disease. New England J. Med., 214:277, 1936.

100. The basal metabolic rate was +24. An electrocardiogram (Fig. 1) taken during an attack of angina showed a regular sinus rhythm; deep depression of $ST_1$, $ST_2$ and $ST_4$; deep inversion of $T_1$ and $T_4$, and left axis deviation. In an electrocardiogram taken 15 minutes later, the $ST_1$, $ST_2$ and $ST_4$ segments were less depressed, and $T_1$ and $T_4$ were diphasic.

Thiouracil was given 0.6 gm. daily for two weeks, followed by a maintenance dose of 0.2 gm. After two weeks the patient felt a great deal better. The pain occurred less often and was not as severe. Nitroglycerine was required only twice in the third week of treatment. In the fourth week, she was able to walk four blocks without pain. After five months of treatment, the patient was entirely free of symptoms. The B.M.R. was then —12. Thiouracil was given over a period of six months. The patient has been free of anginal pain seven months after thiouracil was discontinued.

*Case 2:* C. J., a 46-year-old salesman, had a history of angina pectoris of two years' duration. He had one to two attacks of substernal pain daily which radiated to the left arm. The pain occurred on walking two to three blocks and was relieved by rest.

Physical examination revealed a blood pressure of 146/80. The heart was not enlarged. The sounds at the apex and base were normal. No murmurs were heard. An electrocardiogram showed a regular sinus rhythm, deep $Q_3$, a negative $T_3$ and left axis deviation. The B.M.R. was +6.

Improvement was noted after three weeks of thiouracil treatment; the attacks occurred infrequently, were less severe and shorter in duration. After five months, slight pain occurred only under extreme exertion. The basal metabolic rate was —18. The thiouracil was then replaced by a placebo. Within two months the pain occurred with greater frequency and with greater severity. Thiouracil was again given, 0.4 gm. daily for two weeks, then 0.2 gm. for three weeks, followed by a maintenance dose of 0.1 gm. Improvement noted after ten days has been maintained for two months.

*Case 3:* C. R., a 62-year-old salesman, had, during the past 16 months, attacks of substernal pressure, accompanied by numbness in both arms. These occurred on slight exertion or after a heavy meal. He had about three to five attacks a day which lasted about five minutes and were relieved by rest or nitroglycerine.

On physical examination, the heart was not enlarged. The rhythm was regular. The sounds were normal at the apex and base. No murmurs were heard. The blood pressure was 130/70. An electrocardiogram (Fig. 2) during an attack of angina showed a regular sinus rhythm, depression of $ST_1$, diphasic $T_1$ and no deviation of the electrical axis. An electrocardiogram taken 15 minutes after the anginal attack showed $ST_1$ isoelectric and $T_1$ positive. The basal metabolic rate was +4.

After four weeks of thiouracil the patient felt better. He was able to walk a distance of six blocks without pain. Within four months he was entirely free of symptoms. The B.M.R. was then —16. Thiouracil was given over a period of five months. The patient has been free of angina for three months after thiouracil was stopped.

*Case 4:* R. D., a 52-year-old truck driver, had a history of angina pectoris of nine months' duration. The pain which was substernal, was precipitated by heavy lifting, walking one block or climbing one flight of stairs, and was relieved by rest. The pain became progressively worse and he was unable to work for the past three months.

Physical examination revealed a blood pressure of 160/100. The P.M.I. was in the midclavicular line. The sounds at the apex and base were normal, the rhythm was regular and no murmurs were heard. The electrocardiogram showed a deep $Q_3$ and left axis deviation. The B.M.R. was +12.

Improvement was noted after three weeks of thiouracil therapy. The patient was able to walk three blocks without pain. After four months he returned to his occupation as a truck driver. The pain, which occurred only on extreme exertion, was slight. The B.M.R. was —8. Thiouracil was given over a period of five months. Improvement has been maintained three months after the drug was discontinued.

*Case 5:* P. S., a 48-year-old bartender, had a history of angina pectoris of one year's duration. The pain, which was substernal in location, was of great severity and occurred five to eight times a day. It was precipitated by the slightest exertion, lasted about 10 minutes and was relieved by rest.

Physical examination revealed a slight enlargement of the heart to the left. The sounds were normal at the apex and distant at the base. The rhythm was regular. A grade 2 systolic murmur was heard over the mitral area. The blood pressure was 176/100. An electrocardiogram showed a significant $Q_1$ and a small $R_4$ suggesting an old anterior infarction. The B.M.R. was +8.

After six weeks of thiouracil therapy the pain occurred infrequently and was milder. In the third month he had only two attacks of slight pain. The B.M.R. after three months was —20. Thiouracil was given over a period of four months and then replaced by a placebo. After six weeks, the pain occurred more frequently and with greater severity. After two months of placebo thiouracil was again given. 0.4 gm. daily. Improvement was noted after two weeks. After five weeks, the status of the first period of treatment was restored and has been maintained for six weeks.

*Case 6:* C. S., a 46-year-old merchant, had during the past nine months, attacks of severe pain in the upper sternum, radiating to both arms. The attacks were precipitated by exertion, lasted about five minutes and were relieved by rest and nitroglycerine. He had two to three attacks per day.

Physical examination revealed a blood pressure of 120/70. The heart was not enlarged. The rate and rhythm were normal. The sounds at the apex and base were normal. An electrocardiogram revealed a regular sinus rhythm, a deep $Q_3$ and a negative $T_3$. The B.M.R. was —4.

Improvement was noted after four weeks of thiouracil therapy and reached its maximum within

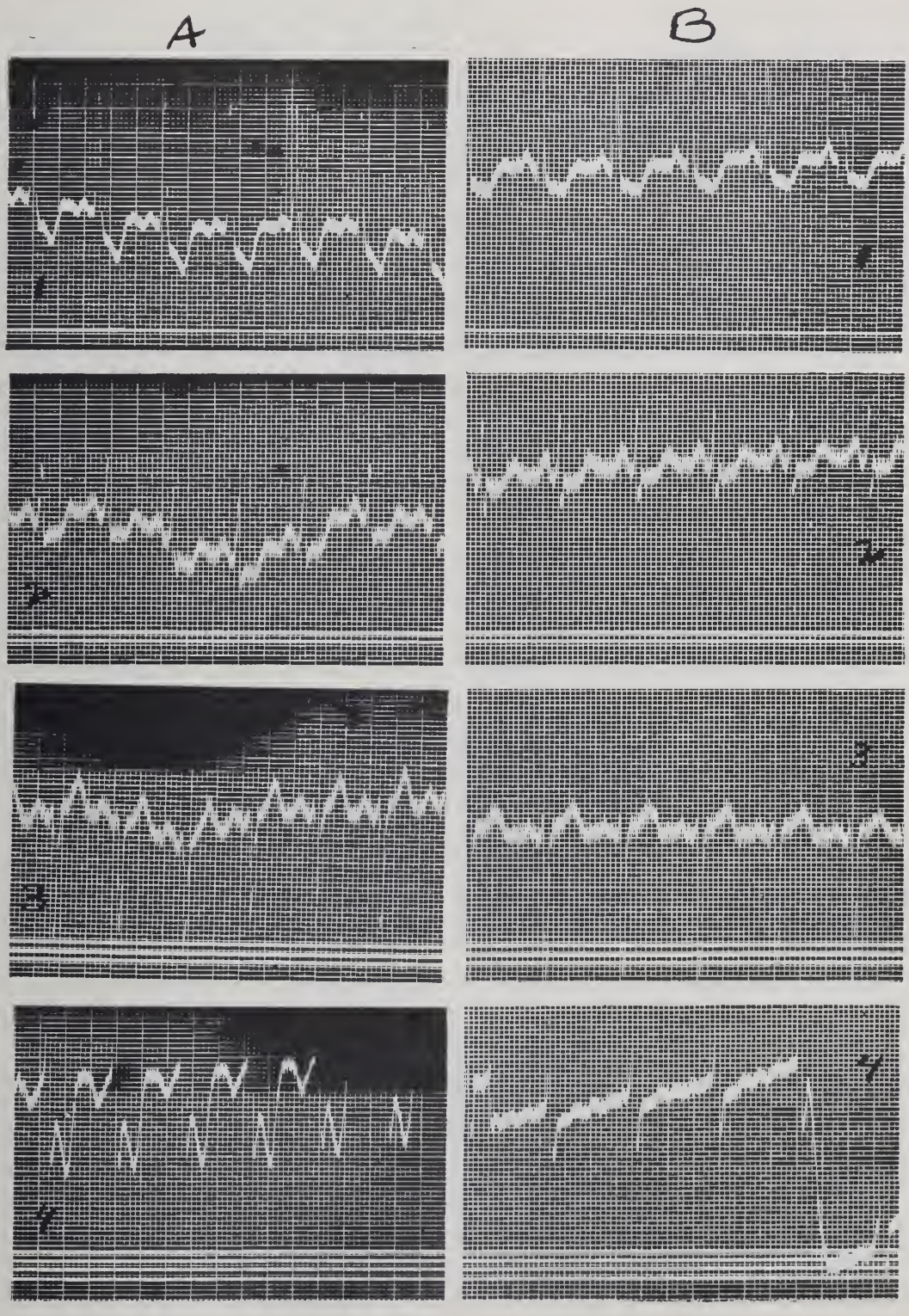



FIGURE 1. (Case 1.) Two records taken 15 minutes apart, A, during, and B, after an attack of angina pectoris. In A there is marked depression of $ST_1$, $ST_2$ and $ST_4$. $T_1$ and $T_4$ are deeply inverted and $T_2$ is diphasic. In B, $ST_1$, $ST_2$ and $ST_4$ are less depressed. $T_1$ is diphasic, $T_2$ is positive and $T_4$ is low and positive.

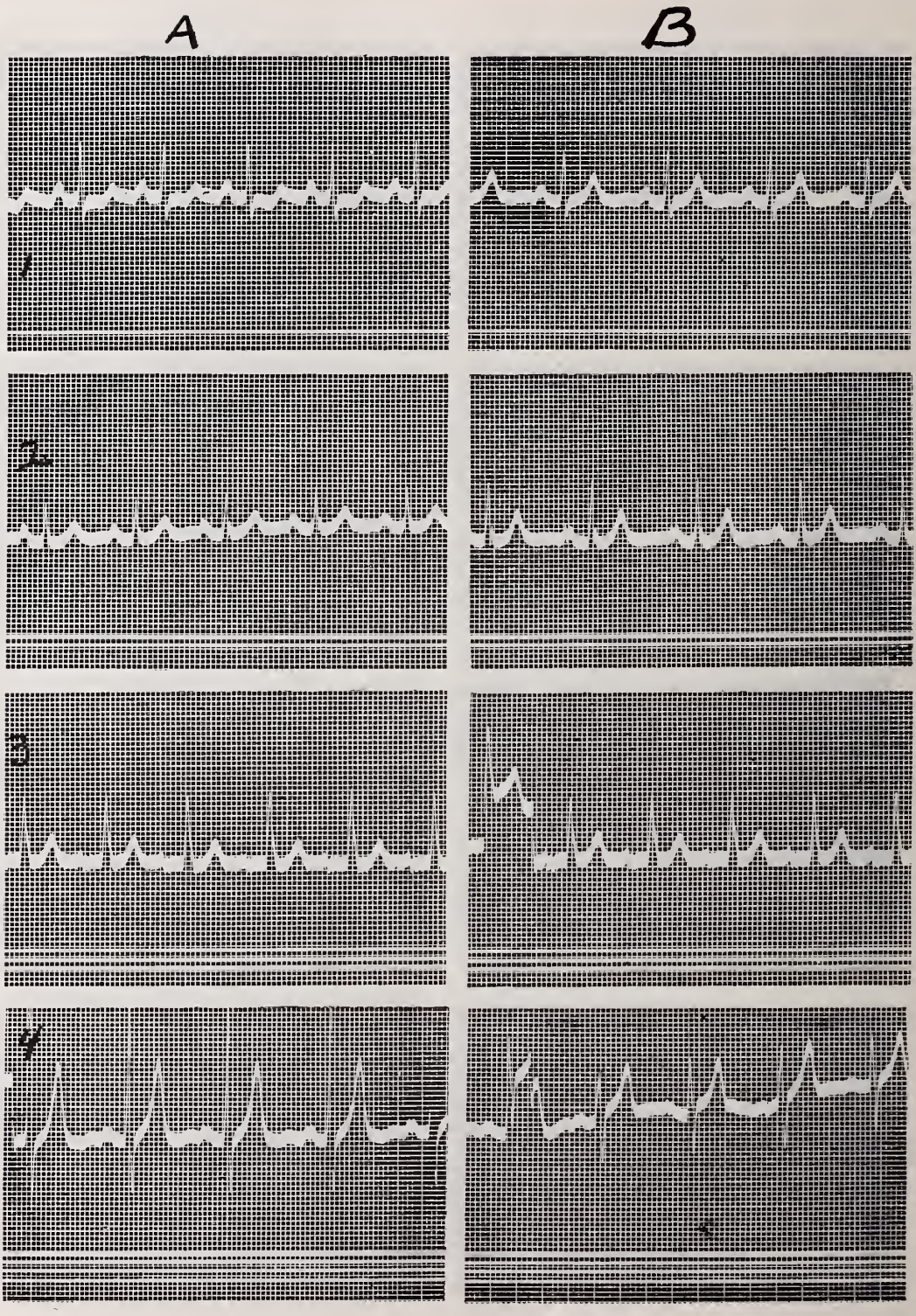



FIGURE 2. (Case 3.) Two records taken 15 minutes apart, A, during, and B, after an attack of angina pectoris. In A there is sagging of $ST_1$ and $T_1$ is diphasic. $P_1$ is notched. In B the ST interval has reached the isoelectric level; $T_1$ has become positive; $T_2$ is higher than in A.

four and a half months. The B.M.R. was then —16. The pain, which occurred only twice in two weeks, was mild and of short duration. Thiouracil was given over a period of five months. Improvement has been maintained for two months after the drug was stopped.

*Case 7:* G. T., a 62-year-old merchant, had a history of angina pectoris of eight years' duration. Substernal pain, radiating to both arms, was induced by the slightest exertion (walking half a block) and occurred sometimes at rest. He had five to ten attacks a day which lasted about ten minutes. He had had an attack of coronary occlusion about eight years ago, at which time he was confined to bed for two months. He also had intermittent claudication for the past ten years.

Physical examination revealed the heart to be enlarged to the left. The sounds were fair at the apex and distant at the base. A grade 2 systolic murmur was heard at the apex. The rhythm was regular. The pulsations of the pedal arteries were not felt in the left leg and were faint in the right. The blood pressure was 200/120. The electrocardiogram showed depressed $ST_1$, $ST_2$, small $R_4$ and marked left axis deviation. The B.M.R. was +16.

After six weeks of thiouracil therapy the attacks were not as severe and of shorter duration. After six months he still could not walk more than one block without pain. The B.M.R. was —12. There was no change in his status when placed under a placebo for two months.

*Case 8* C. R., a 47-year-old clerk, had attacks of pain during the past 15 months in the lower sternum radiating to both arms. The pains were moderately severe and occurred three to five times a day. They were precipitated by exertion (walking a distance of three blocks) and were relieved by rest or nitroglycerine.

On physical examination the heart was not enlarged, the rhythm was regular, the sounds were distant and no murmurs were heard. The blood pressure was 126 systolic and 70 diastolic. An electrocardiogram showed a low $T_1$ and $T_2$. The Q R X complexes were notched in the limb leads. The basal metabolic rate was —6.

Improvement was noted after four weeks of thiouracil therapy. The pains were less severe and of shorter duration, and he was able to walk for a distance of six blocks. After four months of treatment an attack occurred only upon extreme exertion. He had two mild attacks lasting a second in a period of three weeks. The thiouracil was given over a period of four and a half months. The basal metabolic rate was —18. The improvement was maintained six weeks after the thiouracil was discontinued.

## COMMENTS

Analysis of the eight cases (Table 1) shows that the basal metabolic rate before treatment was slightly elevated in one case, and within normal limits in seven cases. The results ob-

RESULTS OF THIOURACIL TREATMENT IN ANGINA PECTORIS

| Case No. | Age | Sex | Duration of Angina Pectoris | B.M.R. Before Treatment | Condition Before Treatment | Onset of Improvement | B.M.R. at Time of Maximum Improvement | Results | Comments |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 54 | F | 5 years | +24 | Attacks of great severity on slight exertion or emotion; 8-10 daily. | 2 weeks | —12 | Excellent | Improvement maintained 7 months after drug was stopped. |
| 2 | 46 | M | 2 years | + 6 | 3-6 attacks daily, moderate severity. | 3 weeks | —18 | Good | Relapse under 2 months of placebo. Improved with 2d course of thiouracil. |
| 3 | 62 | M | 1¼ years | + 4 | Attacks of great severity on slight exertion; 3-5 daily. | 4 weeks | —16 | Excellent | Improvement maintained 3 months after thiouracil was stopped. |
| 4 | 52 | M | ¾ year | +12 | Moderately severe attacks. | 3 weeks | — 8 | Good | Improvement maintained 3 months after drug was stopped. |
| 5 | 48 | M | 1 year | + 8 | Attacks of great severity; 5-8 daily. | 6 weeks | —20 | Good | Relapsed under 6 weeks of placebo. Improved with 2d course of thiouracil. |
| 6 | 46 | M | ¾ year | —4 | Attacks of great severity; 2-3 daily. | 4 weeks | —16 | Good | Improvement maintained 2 months after drug was stopped. |
| 7 | 62 | M | 8 years | +16 | Attacks of great severity on slight exertion and at rest. | 6 weeks | —12 | Fair | Attack less intense and shorter duration. Pain on walking one block. |
| 8 | 47 | M | 1¼ years | — 6 | Attacks of moderate severity; 3-5 daily. | 4 weeks | —18 | Good | Improvement maintained 6 weeks after thiouracil was stopped. |

tained were excellent in two cases; good in five cases; fair in one case.

Of the two cases with excellent results, one has been symptom free seven months after the thiouracil was discontinued; another for three months. In three of the five patients with good results, the improvement has been maintained for a period of six weeks to three months after the thiouracil was stopped. Two patients had relapses when the thiouracil was replaced by a placebo. Both, however, improved again when the thiouracil was readministered. The basal metabolic rate varied from —8 to —20 at the time of maximum improvement. No ill effects were noted as a result of thiouracil medication.

The explanation for the beneficial results obtained with thiouracil in angina pectoris is probably the same as for total thyroidectomy. Levine and Eppinger [4] believe that apart from the main effect in decreasing the work of the heart by decreasing the basal metabolic rate, thyroidectomy also alters the sensitivity of the heart to adrenalin. These authors found that the rise in blood pressure and pulse rate induced by the intramuscular injection of adrenalin was greatly diminished when the test was repeated after total thyroidectomy. They also have shown that when adrenalin produced an attack of angina pectoris, the injection did not cause an attack after the operation. They therefore conclude that the improvement following thyroidectomy may be brought about by a diminished sensitivity of the heart to adrenalin.

Shambaugh and Cutler [5] suggest that therapeutic results of thyroidectomy in angina pectoris may be due to an interference with the thyro-adrenal mechanism. Anginal pains are frequently associated with a rise in blood and pulse rate caused by a sudden increase in the secretory activity of the adrenals. The beneficial results of thyroidectomy, they suggest, may be due to a diminished effectiveness of the physiological output of adrenalin.

It is realized that spontaneous improvement may occasionally take place in angina pectoris. However, because the improvements obtained in some of these cases were so dramatic, and since two cases had recurrences of angina when given a placebo, the therapeutic possibilities of thiouracil can not be ignored. This report is necessarily a preliminary one, and evaluation of the drug must await further investigation over an extended period of time.

SUMMARY

Eight cases of angina pectoris in which thiouracil therapy resulted in definite clinical improvement are reported. The explanation for the therapeutic effect is discussed.

5. Shambaugh, P., and Cutler, E. C.: Total Thyroidectomy in Angina Pectoris. Am. Heart J., 10:221, 1934.

## MEDICAL CARE FOR VETERANS

PAUL R. HAWLEY, Major General, M.C., U. S. Army
Medical Director, Veterans' Administration

Public Relations Conference
Council on Medical Service and Public Relations
Chicago, Illinois
October 19-20, 1945

I am going to present to you very briefly and very frankly what we have in mind to improve the medical service of the Veterans' Administration.

This falls into two large problems, one of institutional care of the sick and injured veteran and the other of out-patient care. I presume the large bulk of the membership of the component societies here is interested more in out-patient care than in institutional care and

I shall devote most of my time to explain what we intend and hope to do in that. First, I should say that we have started institutional care. We are trying to get the best people in the United States to help us to put our program into operation. We are going to the medical profession, to people known and respected in the profession for that help, to improve our institutional care by getting attending staffs from the community and from schools near our hospitals.

We are most fortunate in having a man come with us whom you all know, and who you all respect. I just want to tell you that Dr. Paul Magnuson of Chicago is giving up his practice and for a mere pittance is coming full time in our office in Washington to organize the institutional care of the veteran. Dr. Paul Magnuson is here, and I wish to introduce him.

We have people like this who make such sacrifices in the interest not only of the veteran, but in the interest of the medical profession. I think we are going to succeed if we are not stimulated by personal local interests commonly known as politics. The people, on the whole, I think, have been educated rather badly in the care of the veteran, and I sometimes feel that the pressure is brought upon us to build veterans' hospitals much the same as it is to build post offices. That has got to be discouraged. We can only put veterans' hospitals where we can get high-class medical assistance on part-time basis from the outside.

Now let us get to the problem. I think you are more interested in this than institutional care. It is the out-patient problem. At the moment all women veterans are entitled to out-patient care at whatever expense for any disability, service-connected or not service-connected. Men veterans are entitled to out-patient care only for service-connected disability. This introduces an administrative problem in the determination as to whether or not a man going for out-patient care is entitled to it at government expense. However, that is not an insurmountable problem and can be solved in many ways. It can be solved by the ordinary identification card which can be issued to each veteran, and without proclaiming publicly, a code number of disabilities can be used. He can display the card when he comes in. It will show the disability if service-connected and the doctor can look after him with some assurance of his pay.

We don't want to have the veteran treated in any way as a class apart from society. He is a part of society and insofar as possible he should get his medical care just as any other member of society in the United States gets his medical care. In the past it was customary to designate one, usually, or two physicians in the community, as Veterans' Administration physicians. All veterans were forced to go to them. Now there are many exceptions to this rule but in many places the men who either have been recommended by the local society for this position, or who have accepted the position, are men who have plenty of time on their hands and to whom not many other people in the community are going. We should like to reverse that. We should like to have every physician in each community designated as a veterans' physician and we should like insofar as possible for the veteran to choose his own physician in his own community as any other person in the community does.

How are we going to work that out? I don't know how many counties there are in the United States, three thousand or so. The problem may have to be worked out in three thousand different ways. Each county has its own problems—has its own medical problems—and we are not interested in demanding only one plan. We will subscribe to three thousand different plans. We will make the shoe fit the foot of the county society.

I want to tell you of our start, and we have made a start. The Monmouth County, New Jersey, Medical Society last May submitted a plan whereby, as a county society, they would give out-patient care to the veteran. They would establish an out-patient clinic. The clinic would be staffed with various specialists one night a week, or two nights a week, but would be kept open all the time with somebody in attendance for the veteran to come to in an emergency. They would have regular meetings of a rather special staff. They would make the contact with the local regional officers of the Veterans' Administration and would establish the service connection. In cases that are not service-connected these people say, "Well they are a responsibility of the community. If the government pays for them we are no worse off than with any person who walks into the office. We send them a bill and if they pay we get paid." It is the same proposition as any patient who walks into a doctor's office. They have arranged with all the hospitals in the county to furnish the physical arrangement for the out-patient service, the necessary space, and the equipment. The fees to be paid are a subject to be discussed between us, and I shall take up fees in a minute. For some curious reason this proposal of last May was turned

down, and shortly after I went with the Veterans' Administration, about six weeks ago, I heard about it. I immediately telephoned the president of the society and asked if their enthusiasm had been dampened, if they were willing to reopen the subject. Fortunately for the Veterans' Administration they were. They came down to Washington and laid out the plan. There were a few things which under the law we couldn't do but which we adjusted to the satisfaction of both sides.

There was one part of their proposal I thought was extremely unfair to them, that was they were going to operate this thing three months without any expense to the government except the fees paid to the physician. No expense to the government for clerical help, etc. They wanted to make a trial run, establish how much it was going to cost, how much the government ought to pay. They insisted upon the trial run being made at their own expense. This was a most generous offer and they insisted upon it.

Now as to fees. We could no more set a scale of fees in Washington which would be applicable to every community in the United States than we could set a scale of prices for meals to be applicable in every restaurant in the United States, and we don't intend to do it. We don't intend to publish our scale of fees. We told Monmouth County, "You put in a scale of fees you think is fair and equitable to your own people, remembering only one thing—there are many times when a doctor does charge a fee but does not get it. The Government wants to pay as much as is reasonably justified. We don't want to beat the doctor down at all. At the same time we don't think we are in a sound position if we pay the top prices he gets from his wealthiest patients, but you submit us a scale of fees for Monmouth County and we are not going to have much argument about it."

That is for Monmouth County. If we go into metropolitan New York we pay a different scale of fees. Obviously the scale of fees varies with communities and we are going to have no set scale.

The next thing that frightens many people about having anything to do with the Veterans' Administration is the terrific amount of administrative work the doctor has to do. What he does for the patient is the least of his work. He has interminable forms to fill out. In the first place we are going to try to simplify these forms. You must remember that these are pensionable cases, and the government does have to have some permanent record of what is wrong with the patient. This does not have to be as voluminous as it is now, but we do have to have a record. Furthermore, anybody who draws pay from the government has to sign something once a month, or every time he submits a bill, somebody has to fill out a form. Our position is that since the Veterans' Administration requires all this over and above medical care, the Veterans' Administration should furnish the clerical help to do it. And if we establish an out-patient clinic in any town we shall put clerical help in there to fill out the doctor's vouchers for his charges. They will also be available to write up the medical history of the case from his notes on the case, taking away from the doctor any necessity for doing all of this administrative work.

We have only made a start in one county. We hope that the news gets around to other counties because it is essentially a local arrangement. Conditions vary so widely in different parts of the country. We will submit a plan to the thirteen districts when we decentralize. The local regional man will be given authority to deal with local societies, to advise them as to what kind of a plan will meet the requirements of the law and we will get them approved as rapidly as possible, and we would like to see them in operation.

In conclusion, I want to say that in the interest of the veteran, and the interest of the people of the country, we want this care of the veteran to be done by a free and unregimented profession. We want to preserve the structure of medicine in this country. We want a minimum of government supervision of the care of the veteran. We are willing to rely on the large picture for the honest effort of the profession as a profession and we feel—and perhaps it is apropos here, with the discussion which is before you, in the nature of Public Relations—that we are contributing something to the medical profession in giving them an opportunity at no great sacrifice.

(Major General Hawley will address the January meeting of the Welfare Committee of The Medical Society of New Jersey.)

## PROCUREMENT AND ASSIGNMENT SERVICE

### CONVERSION OF INTERN-RESIDENT STAFFS TO PEACETIME BASIS

1. The 9-9-9 program must be reconverted as rapidly as possible.

2. The Surgeons General expect to call to active duty as rapidly as possible every commissioned officer serving as a resident and, therefore, veterans will represent practically the only source of supply with which to fill residencies.

3. Every commissioned officer serving as a resident prevents one more medical officer who has been on active duty from returning to his civilian practice.

4. Large numbers of veterans are now and will become increasingly available to serve residencies.

5. Those officers who have been on active duty are available for continuing periods of service while those who have not will be ordered to active duty as soon as they are released.

6. The quicker you are able to adjust your situation so that you are not dependent upon medical officers who have not been on active duty the sooner you will be able to operate on a peacetime basis.

The 9-9-9 Program was devised in order to supply American hospitals with residents. Without it, every commissioned officer, which represented eighty per cent of each class, would have been called to active duty at the end of twelve months of internship, and the American hospitals would have been practically devoid of residents. The Procurement and Assignment Service made arrangements with the Surgeons General so that a sufficient number of officers could have their active duty orders delayed and the hospitals could have a minimum supply of residents with which to operate during the war. The whole plan constituted a loan of military personnel to civilian institutions by the Surgeons General, and they were willing to enter into the plan because it was perfectly obvious that there was no other supply available with which to keep these hospitals operating.

With the advent of V-J Day, it is imperative that we return to a peacetime plan at the earliest possible moment and, at the same time, permit the Surgeons General to pick up their officers as rapidly as possible. Increasing numbers of veterans who have seen active duty are becoming available for filling such positions and, therefore, the Surgeons General are convinced that it is in order to call to active duty as rapidly as possible every commissioned officer who has not been on active duty.

Hospitals, therefore, must begin at once to appoint veterans to every staff position so that, with rare exception, every military resident can be called to active duty not later than April 1, 1946. As soon as a veteran has been adequately trained to replace a commissioned officer resident that officer should be called to active duty at once without regard to whether or not he has completed the full term of his present deferment. The hospital must notify the State Chairman for Physicians of the Procurement and Assignment Service of the availability of such officers at once. State Chairmen must watch these developments closely. At present veterans will not count in hospital quotas and it will be of great advantage to the hospitals to accept veterans as replacements for the officers they do count in quotas. The great advantage to hospitals in accepting veterans promptly is that they will be orientated to their position before April 1 in anticipation of the fact that after July 1 such veterans will be practically the sole source of supply of residents for civilian hospitals.

*Hospitals and commissioned officers now serving as residents are reminded that any contract with hospitals is wholly subsidiary to their legal obligation to the Army and Navy, and that each individual is subject to active duty orders at the discretion of the Surgeons General.*

Please remember that present deferments were granted by the Surgeons General prior to V-E Day when there was no other supply available to the hospitals. Now that we are past V-E Day and V-J Day and another supply is available — the veterans — it is not in order to continue the deferment of those men who have not seen active duty. In many institutions veterans are applying by the scores for hospital appointments and hospitals should accept them to the greatest extent possible in anticipation of the fact that those not having been on active duty will be called.

In those cases where the hospital desires the services of an officer on active duty in the Army to fill a residency and the hospital is willing to release a deferred commissioned resident who has not been on active duty before the termination of his present deferment period in exchange and he is an officer (1) who has been on active duty for two years or more, (2) who is now stationed within continental United States, and (3) who would accept the appointment, a request for the release of that officer under War Department Circular 296 through the Procurement and Assignment Service will receive immediately prompt and

favorable consideration by the Surgeon General of the Army. *This replacement possibility does not extend to officers on duty with the Navy.*

The Procurement and Assignment Service will continue to recognize their responsibility toward the hospitals and those individual instances very limited in number in which hospitals are unable to secure a veteran after exhausting every effort or an officer who qualifies under War Department Circular 296, will be given consideration by the Procurement and Assignment Service and the Offices of the Surgeons General. Subject to the above general provisions the reconversion from the 9-9-9 program to a peacetime twelve-month service will be conducted in accordance with the following plan: (This outline applies to the April group. Information concerning those who finish their present term before April and after April will be released in the very near future.)

SECTION I

A. Each commissioned officer who is an intern terminating his nine months of internship on April 1, 1946, will continue in his present internship until July 1, 1946. (For exceptions, see below.)

B. Each commissioned officer who is a junior resident terminating his junior residency on April 1 (if he has not already been replaced by a veteran prior to April 1) will be called to active duty on April 1 except in rare cases in which special request for his services is submitted to and approved by the Procurement and Assignment Service and the Surgeon General—such request to be effective only until he is replaced by a veteran and not beyond July 1, 1946.

C. Each commissioned officer who is a senior resident and who is completing his 27 months of service in a hospital following graduation will be called to active duty on or about April 1, 1946, if not replaced prior to that date by a veteran.

D. Senior students who graduate on or about April 1, 1946, are to be accepted for internship on that date. This new group of interns will be allowed to serve internships until July 1, 1947. *This means that hospitals would have a maximum of twice their quota of interns from April to July and their quota of interns from July to the following July. In view of this and in order to maintain equitable distribution of the intern supply quotas for interns will be maintained at their present levels.*

SECTION II

A. The present interns (referred to in Paragraph A. Section I, above) will be called to active duty on July 1, 1946, except (1) those who are called to duty between April 1 and July 1 because the hospitals cannot facilitate both the old and new groups of interns for three full months of overlapping service; and (2) those rare cases where their services are absolutely essential for an additional period in civilian hospitals. Their services will be deemed necessary only in those cases in which the Procurement and Assignment Service and the Surgeons General are convinced that every effort to obtain the services of veterans, physically disqualified or otherwise ineligible men or of women has been made. [N. B. If Congress votes funds to continue ASTP beyond June 30, 1946, the military group in the following class (unless the Army Training Service abandons its present acceleration demands) will become available for internship on January 1, 1947. This would produce a six-month overlap from January to July but it is hoped that this can be avoided.]

B. The present junior residents (referred to in Paragraph D, Section I, above) will be called to active duty as soon as replaced by a veteran and not later than July 1, 1946, with the same exceptions stated in Paragraph A, Section II, above.

C. The new graduates (referred to in Paragraph D, Section I, above), who will complete twelve months of internship on or before July 1, 1947, will be called to active duty on that date. These men may have as much as fifteen months of internship, that is, April 1, 1946, to July 1, 1947.

SECTION III

Please note that by July 1, 1946, you will be almost entirely dependent upon non-military personnel to fill residencies.

This program does not contemplate an interference with the present policy of not including veterans in quotas. In fact, it emphasizes the importance of acquiring the services of such veterans at the earliest possible moment so that they will be adequately trained to serve as replacements for officers now deferred to April 1 and for the period when they will represent practically the entire supply—after July 1, 1946. It must be remembered that it is essential to return to a peacetime basis at the earliest possible moment and anything less abrupt would only delay reaching that goal.

*In the interest of adequate distribution of the available supply of veterans, it is expected that hospitals will not fill their house staff*

*out of proportion to present quotas. Note that these veterans should be used first as replacements and present quotas for residents should not be exceeded until all deferred commissioned officers who have not been on active duty have been released from that particular hospital. This is not contrary to the policy of not counting veterans in quotas until they are sufficiently trained to be used as replacements.*

It will not be necessary to submit Forms 218 for the continuation of interns for the period from April 1 to July 1, referred to in Paragraphs A and B, Section I, above. It will be presumed, however, that the junior residents referred to in Paragraph B, Section I, practically without exception, will not be requested for this period and will be released prior to but not later than April 1 and as soon as they can be satisfactorily replaced by officers discharged or separated from the service.

We cannot emphasize too strongly the necessity of reconverting from the 9-9-9 Program as rapidly as possible and to the greatest extent possible, for the purpose of returning to the July to July twelve-month internship this coming year. The most available and safest supply of physicians to serve residencies will be these who have completed their military obligation to the nation during the war and the duration of the emergency.

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## WITH NEW JERSEY MEDICAL AUTHORS

Compiled by MILDRED V. NAYLOR, Librarian, Academy of Medicine

It is requested that any New Jersey physician who publishes an article outside the state, notify the Editorial Office in Trenton, giving the title of the paper and the name of the periodical, as well as the month, date, volume and page number. It would also be helpful to this office if members would notify us of articles published by their colleagues.

ABBATE, CHARLES C.—Lodi
Avulsion fracture of the ischial tuberosity. J. Bone & Joint Surg. 27: 716-717, Oct. 1945

BLANCHARD, CECIL K—Trenton
Mark time. Pub. Health News 27: 340-41, Oct. 1945

CHESLEY, LEON C., Ph.D., and LAURA O. WILLIAMS, M.D.—Jersey City
Renal glomerular and tubular function in relation to the hyperuricemia of pre-eclampsia and eclampsia. Am. J. Obst. & Gynec. 50: 367-375, Oct. 1945

CHOW, BACON F.—see McKee, Clara M.

FLANAGAN, JOHN J.—Newark (in service)
Instrument for accurate measurement of bone screws. J. Bone & Joint Surg. 27: 723, Oct. 1945

GERENDASY, JULIUS—Elizabeth
Some problems in ano-rectal disease. Clinics 4: 830-840, Oct. 1945

GOLDSTEIN, HYMAN I.—Camden
Pancreatic extract and muscle extract in cardiovascular diseases. Medical Way 7: 3-5, Sept.; 3-4, Oct.; 4-5, Nov. 1945

HANSON, C. G.—see Murphy, Herschel S.

HEMPHILL, JAMES A.—Mount Holly (in service) with others
Study of the late symptoms of cases of immersion foot. Surg., Gynec. & Obst. 81: 500-503, Nov. 1945

JOHNSON, J. F.—Trenton (Eastern Aircraft, Trenton Division) with ROBERT P. WALSH
Experiences with veterans in industry; follow-up report. Indust. Med. 14: 789-794, Oct. 1945

KERN, E. CLARENCE—Montclair
Local reaction to penicillin given by mouth. J. Med. S. New Jersey 42: 326, Oct. 1945

MAHAFFEY, J. LYNN—Trenton
Health to build the peace. Pub. Health News 27: 331-336, Oct. 1945

MCKEE, CLARA M., and BACON F. CHOW—New Brunswick (Squibb Inst.)
Comparison of the value of clarase, penicillinase, and systeine hydrochloride in revealing the presence of contaminating organisms in preparation of penicillin. J. Immunol. 51: 127-131, Sept. 1945

MURPHY, HERSCHEL S.—Roselle, and C. G. HANSON—Cranford
Congenital humeroradial synostosis. J. Bone & Joint Surg. 27: 712-713, Oct. 1945

RAMSEY, MURIEL—Millville
Effects of bilateral salpingo oorphorectomy. M. Woman's J. 52: 29-30, Oct. 1945

ROSEN, EMANUEL—Newark (in service), with A. L. PETER
Importance of injecting air into Tenon's capsule even in cases of foreign bodies within the eyeball. Am. J. Ophthal. 28: 1140-1144, Oct. 1945

ROSEN, EMANUEL—Newark (in service)
An atypical case of Marfan's syndrome. Am. J. Ophthal, 28: 1134-1138, Oct. 1945

WALSH, ROBERT P.—see Johnson, J. F.

WILLIAMS, LAURA O.—see Chesley, Leon C.

# STATE ACTIVITIES

## GONOCOCCUS CULTURE STATIONS IN NEW JERSEY

In the February 1943 issue of The Journal of The Medical Society of New Jersey there appeared an article entitled "Gonococcus Culture Facilities Offered to New Jersey Physicians". Below is a revised list of the culture stations which are coöperating with the State Health Department in providing this service.

Specimen tubes may be obtained at any of the following stations and must be delivered to the incubator at the station *within three hours* after the slant has been streaked. It is emphasized that to *obtain satisfactory results physicians must observe carefully the instructions which accompany each specimen tube.*

Allentown—Farmers Hospital
Asbury Park—Bureau of Health
Atlantic City—Atlantic City Hospital
J. S. Hunt Laboratory, 805 Atlantic Ave.
Kurland Pharmacy, 118 Dewey Pl.
Municipal Hospital
Bayonne—Bayonne Hospital
Belleville—Department of Health, Town Hall
Bloomfield—Health Department
Bound Brook—Bound Brook Hospital
Bridgeton—Bridgeton Hospital
Camden—Camden General Hospital, 5th & Linden Sts.
Cooper Hospital
West Jersey Homeopathic Hospital
Cape May Court House—County Court House
Cranford—Hampton Laboratory, 321 Casino Ave.
Dover—District Health Office, 16 W. Blackwell St.
General Hospital
East Orange—East Orange General Hospital
Health Department
Elizabeth—Elizabeth Biochemical Lab., 1137 E. Jersey St.
Health Department
St. Elizabeth Hospital
Englewood—Englewood Hospital
Franklin—Franklin Hospital
Hackensack—District Health Off., Rm. 207, Administration Bldg.
Hoboken—St. Mary's Hospital
Irvington—Health Department
Jersey City—Christ Hospital
Hudson County Board of Health Lab.
Medical Center
Physicians and Surgeons Clinical Laboratory, 591 Summit Ave.
St. Francis Hospital
Kearny—West Hudson Hospital
Keyport—Health Department
Lakewood—Paul Kimball Hospital
Linden—Health Department, City Hall
Long Branch—Board of Health, City Hall
Monmouth Memorial Hospital
Mays Landing—District Regional Health Office
Millville—Millville Hospital
Montclair—Health Department, 65 Chestnut St.
Montclair Community Hospital
Mountainside Hospital
Morristown—All Souls' Hospital
Morristown Memorial Hospital
Mount Holly—Burlington County Hospital
Neptune—Fitkin Memorial Hospital
Neptune Twp. Board of Health
Newark—American Legion Hospital
Asen Clinical Lab., Medical Tower
Beth Israel Hospital
City Hospital
Coit Mem. Babies' Hospital
Columbus Hospital
Community Hospital
Newark Memorial Hospital
Presbyterian Hospital
St. Barnabas Hospital
St. James Hospital
St. Michael's Hospital
New Brunswick—Middlesex General Hospital
St. Peter's Hospital
New Monmouth—Middletown Health Center
Newton—Newton Memorial Hospital
Nutley—Department of Health, Municipal Bldg.
Ocean City—Friel Clinical Laboratory, 332 Asbury Ave.
Orange—Orange Memorial Hospital
Passaic—Beth Israel Hospital
Dr. Ogden's Clinical Laboratory, 20 Grove St.
Passaic General Hospital
St. Mary's Hospital
Physicians Laboratory Service, 199 Monroe St.
Perth Amboy—Perth Amboy General Hospital
Phillipsburg—Warren Hospital
Pitman—District Health Office, 13½ S. Broadway
Princeton—Health Department
Princeton Hospital
Rahway—Rahway Hospital
Red Bank—Monmouth Clinical Lab., Rm. 28, Zobel Bldg., 157 Broad St.
Riverview Hospital
Riverside—Zurbrugg Hospital
Roselle—Board of Health
Salem—Salem County Memorial Hospital
Secaucus—Hudson County Contagious Disease Hospital
Somers Point—Shore Memorial Hospital
Somerville—Somerset Hospital
Summit—Health Department, 71 Summit St.
Overlook Hospital
Sussex—Alexander Linn Hospital
Trenton—McKinley Hospital
Mercer Hospital
St. Francis Hospital

Union City—Hudson Diagnostic Lab., 408 36th St.
Board of Health, Town Hall
Vineland—Newcomb Hospital
Weehawken—North Hudson Hospital
Westfield—Board of Health
Clinipath Laboratories, Rialto Bldg.
West New York—General Research Laboratory, 444 W. 60th St.
Woodbury—Underwood Hospital

Note: If your community is not included in the above list and gonococcus culture facilities are not otherwise readily available, we suggest that you discuss the matter with your local health officer or communicate with the State Health Department.

A culture station must have a refrigerator and incubator which are accessible at all times.

## SUPPLEMENTARY LIST NO. 3 TO THE OFFICIAL LIST OF MEMBERS OF MARCH 1, 1945

The figures in parentheses refer to County Societies as follows: (1) Atlantic, (2) Bergen, (3) Burlington, (4) Camden, (5) Cape May, (6) Cumberland, (7) Essex, (8) Gloucester, (9) Hudson, (10) Hunterdon, (11) Mercer, (12) Middlesex, (13) Monmouth, (14) Morris, (15) Ocean, (16) Passaic, (17) Salem, (18) Somerset, (19) Sussex, (20) Union, (21) Warren.

Baird, Thompson M., 168 Magnolia av., Arlington (7)
Balis, Samuel B., 27 S. 9th st., Newark (7)
Byrnes, Elizabeth W., 38 Melrose av., E. Orange (7)
Carlucci, Angelo M., Skillman Village, Skillman (18)
Crissey, Eleanor, 921 Bergen av., Jersey City (9)
DeHart, George K., 132 Sunset av., Verona (7)
Deibert, Kirk R., Washington Univ., St.Louis,Mo.(4)
Dresel, Irmgard, Far Hills (18)
Filippone, Ames L., 171 Clifton av., Newark (7)
Goldman, David, 42 W. 22nd st., Bayonne (9)
Hamblin, Donald O., Mt. Horeb rd., Martinsville (18)
Hollinger, Chauncey O., 253 Harrison av., Jer.C'y (9)
Hunter, Harold H., 114 W. Broad st., Paulsboro (8)
Huss, Louis, 4313 Bergenline av., Union City (9)
Klein, Allan A., 8628 Boulevard, North Bergen (9)
Lifland, Bernard D., 70 Shanley av., Newark (7)
Lind, Zolton H., Middlesex Gen. Hosp., NewBr'k(12)
McCullough, Walter A., Essex Co.Hosp.,CedarGr.(7)
Pegau, Paul M., 246 Briar Hill lane, Woodbury (8)
Schiffman, Samuel, 107 Spruce st., Newark (7)
Schneider, Leo, 39 Hillside av., Newark (7)
Sinclair, Paul F., 570 Bramhall av., Jersey City (9)
Stearns, Thornton, 312 S. Harrison st., E. Orange (7)
Urban, Lawrence J., 679 Ave. C, Bayonne (9)
Vista, Henry A., 274 Barrow st., Jersey City (9)
Warne, Merna Mary, N. J. State Hosp., Greystone Park (14)

ASSOCIATES

Brady, Frank J., 1038 S. Orange av., Newark (7)
Marshall, Irving, 544 S. Warren st., Trenton (11)
Rosso, John D., Princeton Hosp., Princeton (11)

## NUTRITION IN EVERYDAY PRACTICE

S. WILLIAM KALB, M.D., Newark, N. J.

Nutrition Representative, Tuberculosis and Adult Disease Control Advisory Committee to the Subcommittee on Public Health

1. *Are vitamins beneficial in the treatment and control of diabetics?* The carbohydrate tolerance is usually improved and the daily insulin requirements are reduced in diabetics who receive the B complex in combination with vitamin C and increased amounts of thiamine. The added amount of thiamine exerts an influence on the other members of the B complex. It has long been known that where the diet is vitamin-poor the insulin requirement is increased.
2. *Has Vitiligo a nutritional background and if so, what is the treatment?* While vitiligo is usually found in dietary changes it may also occur as a result of or in conjunction with faulty metabolism, hormonal imbalance, and avitaminosis. Therapy has been favorable in a majority of cases by using para-aminobenzoic acid orally (100 mg. t.i.d.) and monoethanolamine para-aminobenzoic acid parenterally (200 mg. daily for 6-9 months). This is used in conjunction with Vitamin B complex and whatever endocrine product may be called for to restore the hormonal imbalance such as thyroid, estrogen, A.P.L., etc.
3. *There has been a great deal in the literature about supplementing vitamins during pregnancy. Is this really necessary?* Recent investigators have demonstrated that pregnant women on well-balanced diets which included meat or meat substitutes

(cheese, milk, or eggs), two leafy vegetables and a citrus fruit daily were healthy. They gave birth to normal, well developed, and well nourished babies just as frequently as those patients to whom vitamins were given daily. It is reassuring to know that a well balanced diet alone serves nutritional purposes to every extent.

4. *How can I make a diagnosis of some of the common vitamin deficiencies in the office without any elaborate laboratory equipment?* The history and physical examination must reveal at least three or more signs or symptoms from one of the columns below to designate the specific vitamin deficiency. No diagnosis should be made with less than *three signs or symptoms.* For example: night blindness, diarrhea, and dry skin found in column marked vitamin A shows deficiency of A. If night blindness and dry skin were the only signs found in this column, no vitamin A deficiency should be diagnosed.

| VITAMIN A | VITAMIN $B_1$ | VITAMIN $B_2$ |
|---|---|---|
| Papular eruption of skin | Anorexia | Glossitis |
| Nightblindness | Polyneuritis | Dysphagia |
| Xerophthalmia | Trigeminal Neuralgia | Fissures at angle of mouth |
| Keratomalacia | Calf muscle tenderness and cramps | Keratoses of the nasolabial folds |
| Patients on low fat diets | Twitching of eyelids | Keratitis |
| Following Cholecystectomy | Foot drop | Soreness and swelling of eyelids |
| Severe infections | Gastric ulcer | Blepharospasm |
| Chronic diarrhea | Constipation | Corneal ulcers |
| Photophobia | Vertigo | Lacrimation |
| Retarded growth | Painful menses | Conjunctivitis |
| Dry skin | Edema | Cataract |
| Frequent respiratory infections | Palpitation | Eye fatigue |
| | Sinus arrythmia | Photophobia |
| | Intolerance to cold | Pemphigus |

| NIACINAMIDE | VITAMIN C | VITAMIN D |
|---|---|---|
| Pellagra | Scurvy | Delayed bone growth |
| Scarlet red glossitis | Ecchymoses of unknown origin | Rickets |
| Muscular atrophy | Gingivitis | Defective tooth structure |
| Poor memory | Achlorhydria | Malnutrition |
| Vertigo | Bronchial asthma | |
| Desquamation | Herpes | |
| Masklike expression | Herpes Zoster | |
| Delirium tremens | Pulmonary tuberculosis | |
| Multiple sclerosis | Rheumatoid arthritis | |
| Deafness | Poor surgical wound healing | |
| Cracked and chapped lips | Debility of old age | |
| Corneal ulcer | Essential hypertension | |
| Scrotal dermatitis | Catarrhal gastro-enteritis | |
| Scanty or absent menses | Pregnancy | |
| Decreased libido | | |
| Sterility | | |
| Burning urination | | |
| Burning of hands and feet | | |
| Toxic symptoms from sulfonamide therapy | | |

## OBITUARIES

### DR. WILLIAM GAUCH

Dr. William Gauch, former president of the medical staff of City Hospital, died on November 13, 1945, at his home in Newark.

Dr. Gauch was born in Newark in 1873. He was a graduate of old Newark High School and received his medical degree from the College of Physicians and Surgeons, New York, in 1895. During World War I he served as a captain in the Army Medical Corps.

Dr. Gauch was associated with Presbyterian, St. Michael's and St. James's Hospitals and was Chairman of the First Fall Clinical Conference of The Medical Society of New Jersey. He was a member of the Essex County Medical Society, The Medical Society of New Jersey and the American Medical Association.

### DR. MAURICE I. KLEIN

Dr. Maurice I. Klein of East Orange, eye, ear, nose and throat specialist, died on November 21, 1945, at Memorial Hospital, New York.

Born in Austria in 1882, he came to this country as a boy and practiced in Newark from 1905 until his retirement 14 years ago, when he was divisional chief of staff at Beth Israel Hospital.

After receiving his M.D. degree from the University of Maryland in 1902, and doing post-graduate work in Europe, Dr. Klein opened a private hospital in Newark, the first in the state devoted exclusively to eye, ear, nose and throat treatment.

In 1938 Dr. Klein attracted nation-wide notice when he presented findings to the American Institute of Physics on "The Stimulating and Depressive Effect of Musical Vibrations on Ichthyopsida".

This showed how fish responded to musical vibrations.

### DR. JOSEPH SCHAPIRO

Dr. Joseph Schapiro of Union City, who for many years was medical director of Union City public schools, died suddenly of a heart attack at his home on November 13, 1945.

Dr. Schapiro was born in Austria in 1880 and went to New York when he was eight years of age. He attended New York public schools and was graduated from Physicians and Surgeons College of Medicine in 1905. He practiced in New York until the outbreak of World War I. He served 18 months in the Medical Corps in France. In 1919 Dr. Schapiro settled in Union City.

Dr. Schapiro was a member of the Hudson County Medical Society, The Medical Society of New Jersey and the American Medical Association. He was a former president of the North Hudson Physicians Society, was on the staff of North Hudson Hospital and on the courtesy staff of the Medical Center.

### DR. R. HUNTER SCOTT

Dr. R. Hunter Scott, who practiced medicine in Newark 36 years, died on November 21, 1945, of a heart attack.

Dr. Scott was born in Richmond, Va., in 1876. He was graduated from the Medical College of Virginia in 1901 and practiced in Richmond before moving to Newark.

An expert in pediatrics, Dr. Scott was head of the pediatrics division in City Hospital and Presbyterian Hospital, and was an attending physician and staff member of Baby's Hospital. He was a licentiate of the American Board of Pediatrics.

Dr. Scott was a member of the Essex County Medical Society, The Medical Society of New Jersey and the American Medical Association.

### DR. HENRY SPENCE

Dr. Henry Spence, practicing physician and surgeon in Jersey City for 52 years, died at the Medical Center on November 22, 1945.

Born in Starkey, N. Y., in 1865, Dr. Spence received his M.D. degree from Columbia College of Physicians and Surgeons in 1892. He interned at Christ Hospital and practiced in Jersey City since 1893.

Dr. Spence was on the staff of Christ Hospital, the Margaret Hague Maternity Hospital and St. Francis Hospital.

He was a fellow of the American College of Surgeons, and a member of the Practitioners Club of Hudson County, Hudson County Medical Society, The Medical Society of New Jersey and the American Medical Association. Dr. Spence served as president of the Jersey City Board of Health in 1922 and 1923.

### DR. S. HENRY SULOUFF

Dr. S. Henry Sulouff, 70, of Summit, who practiced medicine continuously in Jersey City for 44 years, died on November 2, 1945, at All Souls Hospital, Morristown, following a long illness.

Born in Paterson, Pa., Dr. Sulouff was graduated from the Philadelphia College of Pharmacy in 1896 and from the University of Pennsylvania Medical School in 1900. He served as a captain in World War I.

For many years Dr. Sulouff held various offices on the Board of Health. He was a member of the Hudson County Medical Society, The Medical Society of New Jersey and the American Medical Association.

## COMPULSORY MEDICAL INSURANCE

Of the five proposals which President Truman incorporated in his message to Congress on a national health program the one certain to get closest scrutiny concerns compulsory medical insurance. From the comment so far made it is clear that Congress is ready to give to this message the attention its importance merits, but that this readiness is not synonymous with readiness to act.

Congressional action will depend, in the main, on whether or not the President's judgment is accurate when he says that what he proposes is not socialized medicine. It is Mr. Truman's opinion that the decisive factors are that the patient will still be able to select his physician and the physician will still be able to choose his patients. It remains to be seen whether Congress will agree that this is the real test. The whole plan calls for the Federal government to play a large part in deciding upon the location of hospitals, the education of physicians and even, by implication, where physicians shall practice. The medical insurance plan calls for impositon of a tax of 4 per cent on income up to $3,600 a year, and for distribution of part of the proceeds of that tax as payment of the physicians taking part in the plan. There is the further clear implication that the Federal government will determine the fees that physicians shall receive for services under the plan.

It will seem to many persons that President Truman has not gone far enough in testing this plan for marks of socialized medicine. The Federal government would have complete control over collection and distribution of funds; it would have a corresponding say in fixing various standards to be met by communities or individuals. If this did not lead to socialized medicine, it would clearly result in firm establishment of Federal control over a large area of medical practice.—Editorial, The Sun, New York, November 23, 1945.

# COUNTY SOCIETY REPORTS

## ATLANTIC COUNTY

Walter B. Stewart, M.D., Reporter

The *Atlantic County Medical Society* held its monthly meeting on Friday, November 9, 1945, at 9:00 p.m. in the Chelsea Hotel. The guest speaker of the evening was STANLEY P. REIMANN, M.D., Director of the Research Institute of the Lankenau Hospital, Philadelphia, whose subject was: "The General Care of the Cancer Patient". Many *cases* of cancer are treated but it is often forgotten that they are *patients* too, all parts of whom must be considered, as well as the patient himself. The diagnosis of cancer must be made by the pathologist, who wants to see the lesion as near its inception as possible. The lump in the breast must be removed and examined when first discovered, at which time diagnostic error will not be over three per cent. For diagnosis in this area, operation is better than biopsy, though the trocar is satisfactory in most other parts of the body. Be sure to also remove some surrounding tissue with the lesion. Diagnosis is made best with a low-power lens and a high-power brain. If, even in the smallest lump, the diagnosis of cancer is made, nothing short of a radical operation is indicated, or radical irradiation, or both. It does no good to spray around a few electrons. However, the patient must be in good condition for irradiation, since it requires stamina on his part to take it. This idea of radical treatment, in which every last cancer cell is eliminated to prevent recurrence, must be sold to the patient or his family, best by the family physician. We usually do not grade cancers, because it makes little difference in the outcome and is of interest to only the pathologist. Many patients die not of carcinoma but of some complicating factor, such as pyelonephritis, sepsis, or hemorrhage. It should be our aim to keep the patient alive a little longer than first anticipated, for the future always holds hopes of some new cure, some means of improving or prolonging his life.

The diet kitchen is often of more importance than the drug store to the cancer patient, whose loss of appetite may be an outstanding symptom. You may be able to increase his food intake by offering him more on his tray than you expect him to eat, and by diverting his mind from his troubles with discussions of some hobby of mutual interest. A little alcohol in the form of a highball or a drink of sherry before the meal, provided the patient has been accustomed to it, may be helpful. Food is of great importance, supplying materials needed for the regeneration of body tissues and blood, and as sources of energy. Vitamin pills are also an important adjunct.

Mental therapy in these patients is of great value, for most of them, even though they do not have it, are scared of cancer. But better be scared of having it, than having it. The question always arises whether or not we shall tell the patient that he has cancer. If there is a reasonable chance of cure, tell him; but if there is little hope, lie to him like a gentleman. Occasionally, because of business reasons, he must be told. In deciding in which member of the family to confide, or who the responsible person is, the family doctor should be consulted. Do not predict how long the patient still has to live, for too often you are wrong. The doctor should tell the patient before operation that a breast will be removed or a colostomy done, not because of cancer but to eliminate any chance of it. He should tell of many cures of similar cases in an effort to maintain the patient's morale.

If your patient wants to try a quack cure, never argue the point with him, but refer him for information to authoritative sources. Do not berate the quacks or make martyrs of them. If the "cures" are harmless, just do not worry about it.

In the terminal cases under the care of a member of the family, the doctor can be helpful in suggesting many minor means of making the patient more comfortable, e. g. smoothing out the wrinkles in the sheets, the use of sand bags, and the prevention of noxious odors. In treating sleeplessness, much of which is caused by worry or pain, give enough sedative to do the job, and do not be scared of morphine when indicated. Pain is not seen in early cancer but is often a symptom of late cancer. When wounds or breakdown of tissue occur at the site of an old cancer, it is best to take a biopsy, for you have nothing to lose. Do not continue to irradiate these areas which fail to heal, but remove the entire field and, if no cancer is present, do a skin graft. Even if there are recurrences, these can often be controlled for as long as 10 to 12 years.

## BERGEN COUNTY

H. E. Reinhold, M.D., Reporter

A regular meeting of the *Bergen County Medical Society* was held at Bergen Pines Hospital, Oradell, on the evening of September 11, 1945, and was called to order by the President, DR. FREDERICK G. DILGER, at 9:35 p.m.

DR. DANIEL B. ROTH, Teaneck, was elected to regular membership by transfer from the Bronx Medical Society; DR. HAROLD DAVIS, Bergenfield, was elected to associate membership; and DR. STANTON M. HARDY, Montvale, to courtesy membership.

The speaker of the evening was WALTER J. FARR, M.D., of Teaneck, who was formerly a major in the Medical Corps of the U. S. Army, and spoke of his experiences with an American hospital in India.

Dr. Farr was stationed with an American hospital on the Ledo Road in India and had vast experiences in treating personnel of both the Chinese and American Army as well as some of the natives.

Since there were numerous motor accidents the traumatic service was unusually large, but good results were obtained by the use of plaster casts.

Many tropical diseases were encountered, but the unusually fine sanitation regime as practiced by the U. S. Army kept the incidence of disease at the lowest possible level.

Dr. Farr also followed Merrill's Marauders into the jungles of Burma, and it was here that he treated fresh battle casualties.

The paper was exceptionally interesting and well received by the audience, who asked numerous questions.

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A regular meeting of the *Bergen County Medical Society* was held at Bergen Pines Hospital, Oradell, on the evening of October 9, 1945, and was called to order by the President, DR. FREDERICK G. DILGER, at 9:45 p. m.

The speaker of the evening was COMMANDER H. EATON, Psychiatrist, of the United States Naval Hospital at St. Albans, N. Y., who spoke on "Psychiatry in Post-War General Practice".

The speaker discussed the more usual psychiatric conditions which the general practitioner would contact among the discharged veterans. He stressed the fact that the Veterans' Bureau could never adequately care for all these patients and therefore the family physician would be forced to assume a great share of the burden.

Veterans with unstable personalities might well resort to violence as a result of mental stress and increase in violent crimes might present a post-war problem.

Head injuries often render the individual vulnerable to psychiatric defects. The usual findings in these cases might be headaches, abnormal electroencephalograms, abnormal psychiatric studies, dizziness, and epileptiform convulsions, low tolerance to alcohol often leading to alcoholism.

Combat reactions are numerous and the background causing them is often elicited by rendering the patient unconscious and then questioning the patient about past events as consciousness is slowly resumed. Malaria, especially the Guadalcanal variety, can occasionally cause mental damage, which is usually accompanied by a reduction of the intellectual capacity and a change in the emotional pattern.

The speaker described these conditions and their treatment very lucidly and the audience was very appreciative.

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A regular meeting of the *Bergen County Medical Society* was held at Bergen Pines Hospital, Oradell, on the evening of November 13, 1945, and was called to order by the President, DR. FREDERICK G. DILGER, at 9:35 p. m.

The Secretary announced the death of DR. CLARENCE W. BYERS of Rutherford on October 25, 1945. A resolution was passed to extend our condolence to his family.

The President presented the Past President's pin to PAST PRESIDENT WILLIAM K. HARRYMAN in person and to RUSSELL TETHER in absentia.

DR. JOHN A. SULLIVAN of Teaneck, DR. LOUIS DELUCA of Ridgewood, DR. DINO D. CALABRESE of Englewood and DR. EUGENE J. AUDI of Ridgewood were elected to associate membership.

The speaker of the evening was EDWARD F. HARTUNG, M.D., Assistant Clinical Professor of Medicine, New York Post Graduate Medical School, Columbia University. He spoke on "Recent Advances in the Treatment of Arthritis".

Acute rheumatic fever and rheumatoid arthritis are really diseases of the periarticular structures which undergo changes in the fibrous tissues in the form of collogen degeneration.

For simplicity, the speaker classified arthritis as—

1. Rheumatic fever
2. Rheumatoid arthritis
3. Gout
4. Osteo-arthritis
5. Specific infectious arthritis

Rheumatic fever can be largely prevented by ingestion of 7½ grains of sulphadiazine twice a day throughout the year. Active cases are best treated by massive doses of sodium salicylate intravenously (10 grams).

Rheumatoid arthritis is best treated by general constitutional measures; transfusions of fresh whole blood, 500 cc. each week for twelve weeks, and gold salts parenterally given continuously for two years.

Gout yields effectively to cochicum in tablet form if given within the first ten years of the disease.

Osteo-arthritis is almost universally prevalent in man and beast and yields best to mechanical restoration and physical therapy.

The speaker answered many questions from the floor and was enthusiastically received.

The meeting adjourned to collation at 11:00 p. m.

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## BURLINGTON COUNTY

T. B. Dickson, M.D., Reporter

A regular meeting of the *Burlington County Medical Society* was held on November 8, 1945, in the Riverton Country Club.

The guest speaker was DR. THOMAS M. MCMILLAN, Associate Professor of Cardiology of the Post-Graduate College, University of Pennsylvania. His topic was "Coronary Artery Disease". He spoke about the senile heart and its lack of reserve. Dr. McMillan had with him two mounted specimens of the network of the coronary arteries which he had made and mounted himself. One was of a young person's heart and the other of an old person's heart. There was a striking difference between them. Angina pectoris, its cause and treatment, was discussed. Pilot attacks of coronary occlusion were described and their implications clarified. Dr. McMillan closed his talk by discussing coronary thrombosis, its symptoms, diagnosis and treatment. There was a general discussion in which almost all the members present took part.

The County Society passed a resolution which is to be sent to the American Medical Association stating that that organization should recognize the general practitioner and arrange suitable meetings for general practitioners at the annual conventions.

The medical care of the veteran was discussed.

Three plans were presented. No definite action was taken, but a committee was appointed to study the three plans and report their findings at the December meeting.

A new position, that of Medical Director of the Workmen's Compensation Bureau of the State Department of Labor, is open for applicants, who must be approved by their County Society before applying. Veterans, or those having industrial or compensation experience, will be given preference.

## CAMDEN COUNTY

Joseph C. Lovett, M.D., Reporter

The *Camden County Medical Society* held its monthly meeting November 6, 1945, at the Camden City Dispensary with Dr. Henry B. Decker, President, presiding. Forty-five members were present.

Dr. Max Weimann introduced the speaker of the evening, Dr. Abraham E. Rakoff, Director of the Endocrine Laboratory at Jefferson Medical College. His subject was "Endocrine Therapy of Menstrual Disorders". The high-lights of Dr. Rakoff's instructive and interesting paper were that the treatment of menstrual disorders require an intimate knowledge of physiology, a thorough history and examination is necessary and often even then we cannot get at the cause. The hormone preparations are very potent substances. It is therefore necessary to have a fundamental knowledge of the physiology of menstruation. He then showed some lantern slides explaining the physiology of menstruation.

We must know what the ovary and pituitary are doing before we can institute endocrine therapy. We have substitution therapy but harm can be done with this therapy if not careful. Another type is stimulation therapy where low doses of irradiation are used. Just how this acts no one knows. It is probably not really a stimulation therapy. This is not safe therapy.

Gonadotropic hormones can be used. Here the difficulty is in giving the hormones in the proper cycle as they occur in nature. In cases where there is a building up of a large amount of hormones for a long time, there is developed an inhibition to the hormones. A fourth way of approach is the use of androgens. Then Dr. Rakoff gave a brief review of the use of gonadotropic hormones. He stated that endocrine therapy is only one approach to menstrual disorders.

The paper was discussed by Dr. Shipps and Dr. Davis. In closing his talk, Dr. Rakoff said progesterone is a sedative only when used with estrogen. Natural estrogens are excellent. Synthetic estrogens are toxic to some patients, but small doses rarely cause toxicity. Natural and synthetic hormones do not have the exact effects. Thyroid alone will often produce remarkable results. It should be given only when clinically indicated.

The business meeting followed. Approved for membership were Drs. Max K. Franz, John J. Bianco and William Lashman.

Dr. Bentley gave the report of the committee on the Veterans Administration, stating that the question will be brought up at a later meeting. Society dues on men coming back from service will be held over until next year. Delegates to the A. M. A. are to be instructed to support the move for a section for General Practitioners.

## HUDSON COUNTY

Harry J. Perlberg, M.D., Reporter

A regular meeting of the *Hudson County Medical Society* was held on November 7, 1945, at the Masonic Club in Jersey City.

Dr. Ruoff, reporting for the Subcommittee on Medical Economics, appointed on November 2, 1945, to study the plans for medical care of veterans, as submitted by Dr. S. W. Johnsen, Chairman of the Welfare Committee of the State Society, stated that this subcommittee had not had sufficient time to render a complete report. He said, however, that the plan outlined by Major Fagley of the Veterans Administration at Lyons indicated a sincere desire on the part of the Administration to coöperate with the medical profession of New Jersey through the State Medical Society, and expressed the opinion that all members of the county society, in good standing, should have an opportunity to become "designated, fee-basis physicians" in accordance with the conditions of whatever plan is adopted.

Various aspects of the problem were discussed by Drs. Londrigan, Maver, McNenney, Ruoff, Schuck and Tyndall.

Dr. Norton, Chairman of the Board of Trustees of the State Society, informed the Society that a meeting of the House of Delegates of the A. M. A. is scheduled to take place in Chicago the early part of December. In order that the wishes of the members of The Medical Society of New Jersey receive due consideration in any plan for medical care of the veteran that may be formulated at that meeting, Dr. Norton said, the Delegates of the State Society to the A. M. A. recently appeared before the Board of Trustees with the request that they be furnished with concrete data based on the opinions and recommendations of the various component societies of the State Society in the matter of medical care for the veteran.

Dr. Ruoff urged prompt action on the part of the Society. A meeting of the subcommittee was scheduled for November 12th to report its findings.

Dr. Tyndall, Chairman of the Post-Graduate Committee, reported a proposed setting-up of programs in the various hospitals of the county under which returned medical veterans would have the privilege of attending weekly lectures, participating in ward rounds at stated times, and being present as observers in hospital clinics. This committee will meet on November 16th to correlate the various programs submitted.

The following were elected to regular membership: Drs. Kurt Marcus, Jersey City; Herman E. Schorr, Bayonne; George P. Schwab, North Bergen, and Edward E. Shapiro, Bayonne.

Mr. Patrick A. Dwyer spoke on "The Development of Malpractice Action".

Drs. Benjamin, Donohoe, Londrigan, Maver, McNenney, Ruoff, Ruvane and Tyndall joined in a discussion of various aspects of this subject.

# WOMAN'S AUXILIARY

## CHRISTMAS MESSAGE

Mrs. William E. Dodd, President

Let us keep Christmas like the Christmasses of yesterday. Let us keep home and the things that home stands for the same as they were before so many of our husbands and sons answered the call of our Country.

Many of those who served have given their lives that this can be a Christmas of thanksgiving; that instead of prison camps, famine and disease the oppressed have been liberated, fed and cared for by a people who will echo the angels' song:

"Glory to God on the highest
And on Earth, peace
Goodwill toward men."

There are many millions of Americans whose faces are missing around the fireside, who even yet must stand to their arms, not only in defense of human freedom but to preserve the right to follow the faith for which Christmas stands.

The New Year will soon be here. It can be an outstanding year for the Auxiliary if we stand to our arms in the defense of the practice of medicine of today and preserve it until they are home whose trust we hold. Perhaps if we listen we may hear One saying, "Well done, thou good and faithful servant."

Your President extends to each one of you happy holiday greetings and an invitation to attend the Board Meeting in Trenton on January 14, 1946.

## DEDICATION

The Woman's Auxiliary to The Medical Society of New Jersey extends an invitation to all Auxiliary members of all Auxiliaries to attend the open Board meeting to be held at 10:30 a. m., Monday, January 14, 1946, in the Executive Offices of the Medical Society at 315 West State Street, Trenton, at which time a dedication of the Auxiliary Room and the unveiling of the Past-President's portraits will take place.

## KNOW YOUR COUNTY AUXILIARY PRESIDENTS

### Camden County

MRS. REUBEN L. SHARP

Mary Elizabeth Chambers was born in Pennsylvania, attended the Lansdowne Schools, and received her A.B. degree at Dickinson College in 1924. She taught in Lower Merion School while taking post-graduate work at Pennsylvania University.

In 1927 she married Dr. Reuben L. Sharp. He practiced in Camden, New Jersey, until he enlisted in the Navy in April, 1942. Commander Sharp has been in the Pacific War Theatre for two years. Mrs. Sharp and their four children have continued to live on their farm near Moorestown.

Mrs. Sharp has just finished a term as President of the Rancocas Valley Branch of American Association of University Women and she is Vice-President of the Burlington County Board of Young Women's Christian Association.

### Essex County

MRS. S. BERNARD KAPLAN



Mrs. S. Bernard Kaplan, President of the Woman's Auxiliary to the Essex County Medical Society, attended Washington Seminary, Oglethorpe University and Social Service Training, Associated Charities in Atlanta, Georgia. She has one daughter, Theresa Louise, who is a student at Randolph-Macon College, Lynchburg, Virginia.

Mrs. Kaplan has been an active member of the Essex County Auxiliary, serving as Program Chairman 1942-1944, Co-chairman of Public Relations 1944-1945, and Director 1943-1945. She was Chairman of the War Participation Committee of the State Auxiliary in 1944-1945.

Mrs. Kaplan served as Vice-President 1941-1943 of the Volunteer League, Newark Beth Israel Hospital; Vice-President 1943-1945, Federation Jewish Women's Organizations of Essex County, and is active in Community Chest and Red Cross Drives.

# AUXILIARY REPORTS

## Atlantic County

Mrs. Samuel Salasin, Chairman of Publicity

At a regular meeting of the *Woman's Auxiliary to the Atlantic County Medical Society* held at the Chelsea Hotel, Friday, November 9, 1945, plans for the annual Christmas party and buffet supper of the Atlantic County Medical Society and Auxiliary were announced.

Following the business meeting, which was conducted by Mrs. Robert Bradley, President, Miss Julia Rowe, valedictorian of the 1945 graduating class of the Atlantic City Hospital School of Nursing, gave an interesting talk on the great need for competent educators in the nursing school. She expressed the opinion that many present students of nursing are anxious to obtain higher education in the nursing field.

Mrs. Samuel Salasin spoke briefly of the cost of tuition for advanced education in this field.

Mrs. Max Weinmann, Haddon Heights, guest of honor at the luncheon and featured speaker on the program, was presented with a gardenia corsage. She gave most interesting reviews on two contemporary books, "Fifty Years a Country Doctor" by Dr. William McCartney, and "Fifty Years a Surgeon" by Dr. C. S. Morris.

Reports were presented by various committee chairmen on the year's work.

## Essex County

Mrs. Rocco Marra, Publicity Chairman

The opening Board meeting of the *Woman's Auxiliary to the Essex County Medical Society* was held Monday, October 22, 1945, at the Academy of Medicine at 11:00 a.m., followed by the regular meeting at 12:00, and luncheon at 1:00 p.m. Guest of honor was Mrs. William E. Dodd, President of the State Auxiliary. Also present was Mrs. Frederick G. Wandall of Clayton, N. J., President-Elect of the State Auxiliary. Guest speakers were: Dr. William D. Crecca, President of the Essex County Medical Society, and Dr. Eugene M. Katzin of Newark.

Both speakers discussed the blood banks, calling attention to the fact that only four hospitals in Essex County maintain blood banks—St. Barnabas's and Beth Israel in Newark and Mountainside and Orange Memorial. Dr. Crecca pointed out that many lives could be saved through such an agency. He paid tribute to the American Red Cross for its war service in sending overseas 13,000,000 pints of plasma. Much educational work on the value of whole blood and plasma was accomplished by the Red Cross, but much more must be done in establishing a county bank, as the patriotic urge will be lacking. There are 24 hospitals in Essex County to be supplied with whole blood or plasma, Dr. Crecca said, and a plan must be worked out to reduce the cost.

Dr. Katzin told of the centuries of experimentation that preceded successful treatments by blood transfusion, beginning in ancient Egypt. He traced the gain in modern treatments made by the discovery and grouping of different types of blood.

The meeting was opened by Mrs. D. E. Kavanaugh of Newark, Vice-President. The President, Mrs. S. Bernard Kaplan of East Orange, told of the Auxiliary's plan to aid in making the Academy Building a center of health education and of the help it hoped to give in establishing a central blood bank.

## Gloucester County

Mrs. C. A. Bowersox, Chairman of Press and Publicity

The *Woman's Auxiliary to the Gloucester County Medical Society* held its regular business meeting Thursday, November 15, 1945, at 9:00 p.m., at the home of Mrs. C. A. Bowersox, Woodbury.

Due to the absence of the President, Mrs. Fred Faux, the Vice-President, Mrs. P. M. Pegau of Woodbury, presided at the meeting.

Mrs. William Pedrick, Secretary, read the minutes of the last meeting. Mrs. George Booth of Westville gave the Treasurer's report.

Mrs. Frederick Wandall of Clayton, Program and Hygeia Chairman, led a discussion on the duties of doctors' wives in relationship to the State Medical Society. She also reported on Hygeia and urged each member to get subscriptions in as soon as possible.

## Hudson County

Mrs. Sidney Chayes, Chairman of Publicity

A regular meeting of the *Woman's Auxiliary to the Hudson County Medical Society* was held Monday, November 5, 1945, at the Young Woman's Christian Association, Jersey City. The President, Mrs. E. A. Murphy of Jersey City, presided.

Mrs. A. C. Ruoff of Union City, Chairman of Public Relations, reported on the progress of the public health contest open to all the seniors of the high schools of Hudson County.

Following the business meeting Professor Richard Nevins, the guest speaker of the afternoon, gave a talk on "And Now Tomorrow". Tea was served at the close of the afternoon.

## Ocean County

Mrs. Emanuel Sickel, Chairman of Publicity

The *Woman's Auxiliary to the Ocean County Medical Society* met at the home of Mrs. Fred Burrell in Barnegat on Friday, November 2, 1945, at 2:30 p.m. Those attending were Mrs. Carl Meyer, President; Mrs. William E. Dodd, President of the State Auxiliary; Mrs. Raymond Taylor, Mrs. Norman Szold, Mrs. A. Goldstein, Mrs. Carmine Pecora, Mrs. Falkenberg and Mrs. Burrell. Mrs. Falkenberg brought with her Mrs. Baverdam, who was visiting in Barnegat during the time of her husband's service with the Medical Corps of the U. S. Army.

Committee reports included plans made by the Public Relations Committee for a public meeting covering several subjects, safety and home health projects, the meeting to be part of a program furthering health consciousness in the schools. The Auxiliary also agreed to coöperate in the contest to secure subscriptions to Hygeia.

## BOOKS RECEIVED FOR REVIEW

General and Plastic Surgery with Emphasis on War Injuries. By J. Eastman Sheehan, M.D. Pp. 345, illustrated. New York, Paul B. Hoeber, Inc. Medical Book Department of Harper & Bros. 1945. $6.75.

Rorschach's Test. Vol. II. A Variety of Personality Pictures. By Samuel J. Beck, Ph.D. Foreword by Roy R. Grinker, Lt. Col., M.C. Pp. 402. New York, Grune & Stratton, Inc. 1945. $5.00.

The Osseous System: A Handbook of Roentgen Diagnosis. By Vincent W. Archer, M.D. Pp. 320, illustrated. Chicago, Year Book Publishers, Inc. 1945. $5.50.

Pediatric X-Ray Diagnosis: A Textbook for Students and Practitioners of Pediatrics, Surgery & Radiology. Pp. 838, illustrated. Chicago, Year Book Publishers, Inc. 1945. $12.50.

Manual of Surgical Anatomy: Prepared under the Auspices of the Committee on Surgery of the Division of Medical Sciences of the National Research Council, by Tom Jones and W. C. Shepard. Pp. 254 with 267 illustrations on 138 figures, 153 in color. Philadelphia & London, W. B. Saunders Company. 1945. $3.00.

Pathology of Tropical Diseases. By J. E. Ash, Col. M.C., U.S.A., and Sophie Spitz, M.D., C.S., A.U.S. Pp. 350 with 941 illustrations, 15 in color, on 257 plates. Philadelphia & London, W. B. Saunders Company. 1945. $8.00.

A Textbook of Surgery by American Authors. Edited by Frederick Christopher, B.S., M.D., F.A.C.S. 4th ed. Pp. 1548 with 1483 illustrations on 762 figures. Philadelphia & London, W. B. Saunders Company. 1945. $10.00.

Prescribing Occupational Therapy. By William Rush Dunton, Jr., M.D. 2d ed. Pp. 151. Springfield, Illinois, Charles C. Thomas, Publisher. 1945. $2.50.

Mitchell-Nelson Textbook of Pediatrics. Edited by Waldo E. Nelson, M.D., with the collaboration of 49 contributors. 4th ed. Pp. 1350 with 519 illustrations on 333 figures, 26 in color. Philadelphia & London, W. B. Saunders Company. 1945. $10.00.

Diseases of the Nose, Throat and Ear. Edited by Chevalier Jackson, M.D., Sc.D., LL.D., F.A.C.S., and Chevalier L. Jackson, M.D., M.Sc., F.A.C.S., with the collaboration of 64 authorities. Pp. 844 with 934 illustrations on 581 figures including 18 plates in color. Philadelphia & London, W. B. Saunders Company. 1945. $10.00.

## BOOK REVIEWS

**Arterial Hypertension:** Its Diagnosis and Treatment. By Irvine H. Page, M.D., and Arthur Curtis Corcoran, M.D. Pp. 352. Chicago, The Year Book Publishers, Inc. 1945. $3.75.

The entire field of hypertension is reviewed in this well written and easily read monograph. The discussion on etiology of essential hypertension stresses psychogenic factors and questions the hereditary factor in this disease. There is very little offered that is new in the way of treatment; the authors seem more enthusiastic about thiocyanate than most.

Louis Grunt, M.D.

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**Clinical Traumatic Surgery.** By John J. Moorhead, B.S., M.D., D.Sc., F.A.C.S. (D.S.M.). Pp. 747 with 500 illustrations. Philadelphia & London, W. B. Saunders Co. 1945. $10.00.

Moorhead's new traumatic surgery gives the busy general practitioner in one volume all the information necessary to diagnose and treat all of the usual, and most of the unusual results of accidental injuries.

In this book, the writer, who is well versed in presenting to the medical profession his own long experience in treating traumatic injuries, has made another valuable contribution to the literature. He presents each individual entity in traumatic surgery in a careful, concise, matter-of-fact way, so that the general practitioner can almost see in his own mind cases of his own general practice, that lie in the various categories outlined in the book.

Each type of treatment is outlined, giving the reader the benefit of the writer's experience in using the various forms of treatment for fractures, etc., telling the reader why he selects one type over the other. Detailed presentation of the clinical treatment of wounds, injuries, fractures, and practical operative procedures for amputation, removal of foreign bodies, etc., are given.

One of the most important features of the book is the medico-legal phase with special reference to compensation, malpractice, and other legal features.

This book is of the utmost importance to all general practitioners and surgeons who come in contact with traumatic injuries.

Marcus H. Greifinger, M.D.

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**Microbes of Merit.** By Otto Rahn. Pp. 277, illustrated. Lancaster, Pa., Jaques Cattell Press. 1945. $4.00.

Dr. Rahn, Professor of Bacteriology, Cornell University, uses everyday language to explain bacteria and trace the history, discovery and significance of bacteriology.

He explains that the "friendly" bacteria are necessary to life itself and to them we owe bread, cheese, linen, explosives, plastics—even penicillin. There are explanations as to why we need bacteria to keep the soil fertile, to supply vitamins, to dispose of sewage and for the manufacture of common foods such as pickles, cocoa and the like.

The understandable explanations of the world without bacteria where there would be no spoilage and no contagious diseases is fascinating. But on the other hand, his description of a world without bacteria—no trees, fertilizers and many of the edi-

bles we enjoy—brings the story down to everyday life and living.

The illustrations are well selected and the whole is worthy of a place in any library. Dr. Rahn has done an estimable job in explaining some of the most complex bacteriological subjects in the language of the layman. Carolyn Valentine, B.S.

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**Classic Descriptions of Disease.** By Ralph H. Major, M.D. 3d ed. Pp. 679 with 158 illustrations. Springfield, Illinois; Charles C. Thomas, Publisher. 1945. $6.50.

Time was when the physician was the cultured man of the community who, like the clergyman and school teacher, was supposed to be at home among the classics. The doctor could be depended on to translate a Latin proverb, explain an algebraic formula, or remember the name of King Arthur's sword. For better or for worse, the contemporary physician has largely forfeited that status. Today, he says that he has enough trouble remembering the dose of penicillin and the varying powers of the sedatives; that he spends too much time seeing patients and attending medical meetings to devote any of his precious leisure to acquiring a historical perspective. The kind of medical book that finds a ready market these days is the one that is filled with effective prescriptions, practice-building hints, or blue-prints of how to perform some new surgical procedure. Dr. Major's book does not fall into that class. There is nothing in this volume that will help you relieve your patient's suffering, improve your collections or expand your practice. But there is much here that will hold your interest and enrich your understanding of the background of medicine.

Dr. Major presents, in English translation, almost 300 original accounts of disease syndromes and clinical pictures. The cited authors range from Hippocrates of Cos to Leo Buerger of New York. The giants of medicine are all here: John Hunter, William Osler, Hutchinson of the teeth and Koplik of the spots, Sydenham and Heberden, Basedow and Paracelsus, Banting, Raynaud, Morgagni, Hodgkin, Stokes, Adams and almost 200 others whose very names are now part of the common currency of medical conversation. Lively biographic sketches of these men of medicine precede each extract. The 158 illustrations furnish a proud gallery of medicine's heroes.

Rereading these classic descriptions of disease gives us a new respect for the clinicians of yesteryear who depended on their heads and eyes and hands, rather than on machinery, scopes and tests. When Addison writes of pernicious anemia he describes "feeling of languor, countenance pale, whites of the eyes pearly, the frame flabby, rather than wasted, the gut soft, the lips bloodless, the surface of the body blanched and waxy". That is a description penned with the eyes of an intelligent observer and the vocabulary of a verbal artist. It may be more scientific these days to describe it all in terms of the P-h, the erythrocyte count and the hemoglobin. But such descriptions never clothe the patient with the living reality of the pictures painted with the words of the old masters.

To those physicians for whom medicine is still a "Learned calling", and for whom the title "doctor" still retains its original meaning, this book will prove a treasure. On the other hand, the practitioner of much knowledge and little learning will see this volume only as a collection of obsolescent errors. He will wonder why any one has bothered to write and why any one wants to read so "impractical" a volume. The answer to that is something that he will never understand.

Henry A. Davidson, M.D.

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**Common Ailments of Man.** Ed. by Morris Fishbein, M.D. Pp. 177. New York, Garden City Publishing Company. 1945. $1.00.

Each of the chapters has been written by a recognized authority in the field. Keefer writes about common colds and respiratory infections; McKinney writes of neuritis and Sulzberger and Baer discuss athlete's foot. There are many more chapters, all of them about everyday afflictions that are visited upon all of us at one time or another.

Each brings out the point that self-medication for a symptom which is a danger signal, may bring on more serious illnesses but that this can be alleviated or prevented entirely if the symptoms are recognized and the proper steps taken in time.

The volume is small but it is a potent means of furthering the layman's knowledge of the ills that are most apt to beset him, their causes, characteristics, progress, and the means that science has found to combat them. The articles were chosen from those appearing in Hygeia.

A book for the laity that does not lack authenticity. Carolyn Valentine, B.S.

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**Essentials of Clinical Allergy.** By Samuel J. Taub, M.D. Pp. 198, illustrated. Baltimore, The Williams & Wilkins Company. 1945. $3.00.

This compact volume contains a methodical review of the most necessary information and procedures in allergic diagnosis and treatment. It is a practical handbook written for those who wish to learn the essentials. There are no controversial nomenclatures, theories or practices presented, and the methods recorded are those which allergists in most parts of the country would consider standard. Finer variations in theory, technique, special problems, and non-specific therapy are not presented. Its direct and non-discursive manner makes it an ideal volume for those who wish to acquire a simple, practical approach to allergic problems.

The longer chapters are on the respiratory allergies with some emphasis on pollenosis. The less frequent and rare allergies such as cardiovascular, genito-urinary and arthritic allergies are also presented.

Emphasis is placed upon thorough history and skin testing. Treatment dosage is recorded in detail. Tables of allergens, diets and instructions to patients form a useful, practical conclusion to the book. Louise Fischer, M.D.

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If you do not bind your Journals, use the table of pages (below) to find the month of issue to which any page citation refers.

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* Original Articles
† Obituary
e—Editorial
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# Tuberculosis Abstracts

*A Review for Physicians*

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

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PATIENTS and their relatives very properly seek from their physicians the latest word on chemotherapy in tuberculosis. Inquiries reach flood stage whenever a new "success" story, often baseless or fragmentary, appears in the public press. Hinshaw and Feldman do the profession a service by presenting in condensed form the present status of drug therapy.

## CHEMOTHERAPY IN TUBERCULOSIS

Efforts to develop an effective medicinal treatment for tuberculosis have undoubtedly been under way ever since this great human pestilence was recognized. The writings of ancient physicians contain repeated reference to herbs and other natural products alleged to be of therapeutic value. When Ehrlich and his contemporaries learned of the value of metallic salts in treating syphilis and parasitic diseases, hope was revived that some such preparation might be of aid in treating tuberculosis. The use of gold salts in the treatment of tuberculosis appears to have been an outgrowth of this line of research, but treatment with these has not withstood the test of time.

The unprecedented success of the sulfa drugs in treatment of many bacterial diseases of man renewed hope that tuberculosis might eventually yield to some such drug, and experiments on guinea pigs have given definite support to these hopes.

In 1939 and 1940 the sulfonamide drugs were shown to have some retarding effect on the rate of development of tuberculosis of guinea pigs, but in no instance did the drugs actually arrest the disease.

The drugs of the sulfone series (promin, diasone and promizole) were the first preparations to succeed in actually arresting tuberculosis in the highly susceptible guinea pig. This led to high hopes that sulfone drugs might be of value in the treatment of human tuberculosis. Several hundred tuberculosis patients have now received treatment with these drugs. Experience has tempered the early enthusiastic hopes of some physicians.

Most sulfone drugs, unfortunately, have a much more toxic effect on human beings than on guinea pigs. It is suspected that some sulfone drugs are altered in the human body and become ineffective. The possibility that sulfone drugs may be of aid in treatment of certain unusual varieties of human tuberculosis has not been excluded, but no definite place has been found for these drugs in treatment of the usual types of tuberculosis. The use of sulfone drugs under any circumstances has not progressed beyond the experimental stages.

The only sulfone drug which has been approved by the Federal Drugs Administration for sale is promin. This is available in jelly form for application on the surface of external tuberculous lesions. The effectiveness of promin has not been completely established even for this special use.

The amazing success of penicillin in treatment of several infectious diseases again aroused hopes that this or a similar antibiotic substance might be developed which would be effective against tuberculosis. Penicillin itself appears to have no effect on tuberculosis in guinea pigs or in man, but many other substances may be extracted from living micro-organisms which can suppress the growth of bacteria which produce disease.

Of these only streptothricin and streptomycin need now be considered. Streptothricin and streptomycin are both derived from soil-inhabiting fungi (*Actinomyces lavendulae and Actinomyces griseus*). Both restrain the growth of tubercle bacilli in the test tube. Streptothricin is somewhat toxic to guinea pigs and does not restrain the development of tuberculosis in these animals.

Streptomycin is well tolerated by guinea pigs, and extensive investigation has shown that it does inhibit in them the growth of experimental tuberculosis. In a third of the guinea pigs treated streptomycin apparently will eradicate advanced

tuberculosis. In the other two thirds treatment with streptomycin will bring the disease to a stage that can be regarded as arrested.

Adequate study of streptomycin in treatment of human tuberculosis remains to be done. Certain obstacles lie in the path of further progress along this line.

Many students of tuberculosis believe that results comparable to those noted in acute diseases, such as pneumonia, should not be anticipated in drug therapy of as generally chronic a condition as tuberculosis. In any disease successful treatment with drugs merely permits recovery by natural processes, and the promptness of such recovery depends on the nature of the disease process and the defensive powers of the patient.

Tuberculosis, however, by virtue of its usual chronicity, produces destructive changes in tissues. Healing or repair of these tissues is exceedingly slow. Furthermore, in extensive tuberculosis of the lungs the destructive changes offer serious mechanical handicaps to healing. When such mechanical handicaps exist a corrective mechanical type of treatment, such as the conventional surgical collapse procedures, is used rather than treatment with a drug. The physician therefore does not hope for any alternative chemical remedy when surgery is indicated. Rest therapy, usually in the planned environment of a sanatorium, will probably remain the fundamental remedy for tuberculosis. No drug now available is likely to supplant rest completely. At this time it would appear foolish to discard the known benefits of rest treatment for the uncertainties of treatment with a new drug.

Patients are frequently eager to receive newly developed drugs even when the hope of benefit is remote. Usually it is impossible to secure such drugs under these circumstances due to present-day legal restrictions designed to prevent unwise distribution of drugs whose safety and efficacy have not been determined.

The distribution of new drugs for the necessary preliminary, laboratory and clinical trials is entirely in the hands of the manufacturers. Investigators receiving drugs for this purpose must have proper facilities to carry out the contemplated research accurately and safely. They also may be called on to account for all of the drug supplied and to submit complete reports of their researches which eventually are forwarded to the Federal Security Agency. Obviously, it is impossible for research workers to share their supplies of new drugs before the necessary research is completed.

Th channels through which information about new scientific developments flows are direct and dependable. When a research worker has completed a project, he submits a report to the editors of one of the many medical and scientific journals, and usually publication of the results of his work follows within a few months. This enables other research workers and physicians to utilize promptly any of these new facts either in treatment of patients or in the development of new scientific information. The prompt publication of results is an ethical responsibility of the scientist to aid others engaged in similar problems. No one need fear that he will be denied any valuable secret remedy.

Newspaper reporters and authors of magazine articles recognize the news value of scientific discoveries. Occasionally they use sources of information less authoritative than those of established medical journals, to the chagrin of research workers and to the confusion of patients. Human lives may be lost needlessly if patients who have tuberculosis choose to forsake or refuse well-established methods of treatment in the hope of receiving remedies inadequately tried or of unproved effectiveness.

*Chemotherapy in Tuberculosis, H. C. Hinshaw, M.D., and William H. Feldman, D.V.M., The NTA Bulletin, Oct. 1945.*

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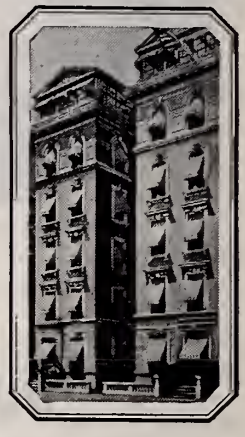
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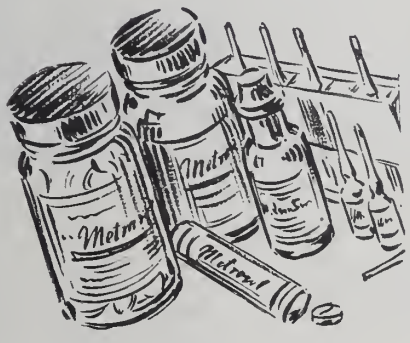
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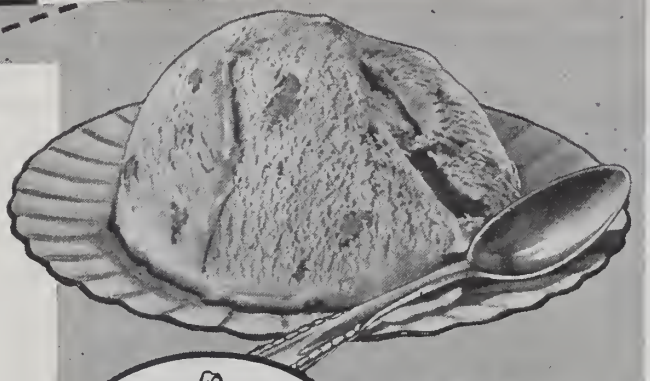
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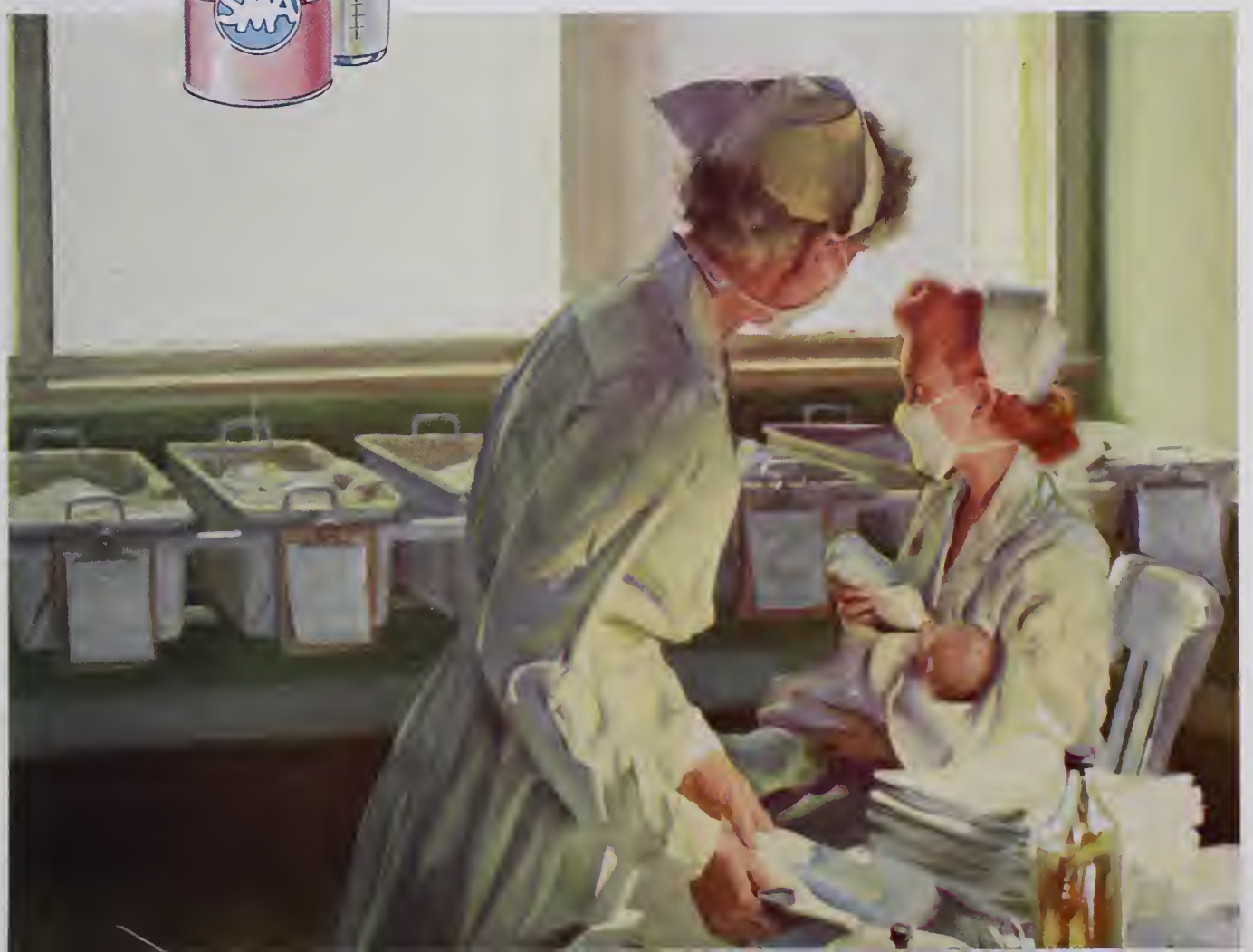
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*Supplement to The Journal of The Medical Society of New Jersey, April, 1945*

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## OF

# THE MEDICAL SOCIETY OF NEW JERSEY

## FOR THE YEAR 1945

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Year of Election

1. 1766—Robert McKean, Perth Amboy, 1732-1767
2. 1767—William Burnet, Newark, 1730-1791
3. 1768—John Cochran, New Brunswick, 1730-1807
   1769—John Cochran, No. 3, reëlected
4. 1770—Nathaniel Scudder, Freehold, 1733-1781
5. 1771—Isaac Smith, Trenton, 1740-1807
6. 1772—James Newell, Freehold, 1725-1791
7. 1773—Absalom Bainbridge, Lawrenceville, 1742-1807
8. 1774—Thomas Wiggins, Princeton, 1731-1801
9. 1775—Hezekiah Stites, Cranbury, 1726-1790

No formal meetings 1776-1780 on account of the War of the Revolution.

1781—James Newell, No. 6, reëlected

10. 1782—John Beatty, Trenton, 1749-1826
11. 1783—Thomas Barber, Matawan, 1730-1807
12. 1784—Lawrence Vander Veer, Roycefield, 1740-1815
13. 1785—Moses Bloomfield, Woodbridge, 1729-1791
    1786—William Burnet, No. 2, reëlected
14. 1787—Jonathan Elmer, Bridgeton, 1745-1817
15. 1788—James Stratton, Swedesboro, 1755-1812
16. 1789—Moses Scott, New Brunswick, 1738-1821
17. 1790—John Griffith, Rahway, 1736-1805
18. 1791—Lewis Dunham, New Brunswick, 1754-1821
19. 1792—Isaac Harris, Middlesex County, 1741-1808

No elections held in 1793 and 1794 because quorum not present.

20. 1795—Elisha Newell, Allentown, 1755-1799

No formal meetings 1796-1806 owing to an attempt to establish a rival society in Eastern New Jersey.

21. 1807—Jonathan F. Morris, Somerville, 1760-1810
22. 1808—Peter I. Stryker, Somerville, 1766-1859
23. 1809—Lewis Morgan, Rahway, 1757-1821
24. 1810—Lewis Condict, Morristown, 1773-1862
25. 1811—Charles Smith, New Brunswick, 1768-1848
26. 1812—Matthias H. Williamson, Elizabeth
    1813—Matthias H. Williamson, continued for second year
27. 1814—Samuel Forman, Freehold, 1764-1845
28. 1815—John Van Cleve, Princeton, 1778-1826
    1816—Lewis Dunham, No. 18, reëlected
    1817—Peter I. Stryker, No. 22, reëlected
    1818—John Van Cleve, No. 28, reëlected
    1819—Lewis Condict, No. 24, reëlected
29. 1820—James Lee, Newark
30. 1821—William G. Reynolds, Manalapan
31. 1822—Augustus R. Taylor, Somerville, 1782-1840
32. 1823—William B. Ewing, Greenwich, 1776-1866
    1824—Peter I. Stryker, reëlected. Also served 1808 and 1817.
33. 1825—Gilbert S. Woodhull, Manalapan, 1794-1830
34. 1826—William D. McKissack, Millstone, 1781-1853
35. 1827—Isaac Pierson, Orange, 1770-1833
36. 1828—Jephtha B. Munn, Chatham, 1780-1863
37. 1829—John W. Craig, Somerset County, 1795-1871
    1830—Augustus R. Taylor, No. 31, reëlected
38. 1831—Thomas Yarrow, Sharptown, 1778-1841
39. 1832—E. FitzRandolph Smith, New Brunswick, 1786-1865
40. 1833—William Forman, Monmouth County, 1796-1848
41. 1834—Samuel Hayes, Newark, 1776-1839
42. 1835—Abraham P. Hagerman, Somerset County
43. 1836—Henry Vander Veer, Somerville, 1792-1874
44. 1837—Lyndon A. Smith, Newark, 1795-1865
45. 1838—Benjamin H. Stratton, Mt. Holly, 1804-1875
46. 1839—Jabez G. Goble, Newark, 1799-1859
47. 1840—Thomas P. Stewart, Hackettstown, 1798-1846
48. 1841—Ferdinand S. Schenck, Six Mile Run, 1790-1860
49. 1842—Zachariah Read, Mt. Holly, 1808-1879
50. 1843—Abraham Skillman, Bound Brook, 1796-1862
51. 1844—George R. Chetwood, Elizabeth, 1802-1885
52. 1845—Robert S. Smith, Bound Brook, 1800-1874
53. 1846—Charles Hannah, Deerfield, 1782-1857
54. 1847—Jacob T. B. Skillman, Woodbridge, 1794-1864
55. 1848—Samuel Hayes Pennington, Newark, 1806-1900
56. 1849—Joseph Fithian, Woodbury, 1795-1881
57. 1850—Elias J. Marsh, Paterson, 1803-1850
58. 1851—John H. Phillips, Pennington, 1814-1878
59. 1852—Othneil H. Taylor, Camden, 1803-1869
60. 1853—Samuel Lilly, Lambertville, 1815-1880
61. 1854—Alfred B. Dayton, Middletown Point, 1812-1870
62. 1855—James B. Coleman, Trenton, 1806-1877
63. 1856—Richard M. Cooper, Camden, 1816-1874
64. 1857—Thomas Ryerson, Newton, 1821-1887
65. 1858—Isaac Pierson Coleman, Pemberton, 1804-1869
66. 1859—John R. Sickler, Mantua, 1800-1886
67. 1860—William Elmer, Bridgeton, 1814-1889

Year of Election

68. 1861—John Blane, Perryville, 1802-1885
69. 1862—John Woolverton, Trenton, 1825-1888
70. 1863—Theodore R. Varick, Jersey City, 1825-1887
71. 1864—Ezra M. Hunt, Metuchen, 1830-1894
72. 1865—Abraham Coles, Newark, 1813-1891
73. 1866—Benjamin. R. Bateman, Bridgeton, 1807-1883
74. 1867—John C. Johnson, Blairstown, 1828-1907
75. 1868—Thomas J. Corson, Trenton, 1828-1879
76. 1869—William Pierson, Orange, 1796-1882
77. 1870—Thomas F. Cullen, Camden, 1822-1877
78. 1871—Charles Hasbrouck, Hackensack, 1818-1877
79. 1872—Franklin Gauntt, Burlington, 1823-1900
80. 1873—Thomas J. Thomason, Perrineville, 1833-1880
81. 1874—George H. Larison, Lambertville, 1831-1892
82. 1875—William O'Gorman, Newark, 1824-1887
83. 1876—John V. Schenck, Camden, 1825-1882
84. 1877—Henry R. Baldwin, New Brunswick, 1829-1902
85. 1878—John S. Cook, Hackettstown, 1827-1900
86. 1879—Alexander W. Rogers, Paterson, 1814-1905
87. 1880—Alexander N. Dougherty, Newark, 1822-1882
88. 1881—Lewis W. Oakley, Elizabeth, 1828-1888
89. 1882—John W. Snowden, Blackwood, 1823-1888
90. 1883—Stephen Wickes, Orange, 1813-1889
91. 1884—Phanett C. Barker, Morristown, 1835-1903
92. 1885—Joseph Parrish, Burlington, 1818-1891
93. 1886—Charles J. Kipp, Newark, 1838-1911
94. 1887—John W. Ward, Trenton, 1840-1916
95. 1888—H. Genet Taylor, Camden, 1837-1916
96. 1889—Beriah A. Watson, Jersey City, 1836-1892
97. 1890—James S. Green, Elizabeth, 1829-1892
98. 1891—Elias J. Marsh, Paterson, 1835-1908
99. 1892—George T. Welch, Passaic, 1845-1924
100. 1893—John G. Ryerson, Boonton, 1834-1916
101. 1894—Obadiah H. Sproul, Flemington, 1844-1925
102. 1895—William Elmer, Trenton, 1840-1908
103. 1896—Thomas J. Smith, Bridgeton, 1841-1932
104. 1897—David C. English, New Brunswick, 1842-1924
105. 1898—Claudius R. P. Fisher, Bound Brook, 1859-1927
106. 1899—Luther M. Halsey, Williamstown, 1858-1921
107. 1900—William Pierson, Jr., Orange, 1830-1900
108. 1901—John D. McGill, Jersey City, 1846-1912
109. 1902—Edward L. B. Godfrey, Camden, 1850-1913
110. 1903—Henry Mitchell, Asbury Park, 1845-1919
111. 1904—Walter B. Johnson, Paterson, 1852-1922
112. 1905—Henry W. Elmer, Bridgeton, 1847-1907
113. 1906—Alexander Marcy, Jr., Riverton, 1860-1934
114. 1907—Edward J. Ill, Newark, 1854-1942

Year of Election

115. 1908—David St. John, Hackensack, 1850-1917
116. 1909—Benjamin A. Waddington, Salem, 1842-1917
117. 1910—Thomas H. MacKenzie, Trenton, 1847-1920
118. 1911—David Strock, Camden, 1850-1927
119. 1912—Norton L. Wilson, Elizabeth, 1861-1931
120. 1913—Enoch Hollingshead, Pemberton, 1843-1924
121. 1914—Frank D. Gray, Jersey City, 1857-1916
122. 1915—William J. Chandler, South Orange, 1842-1927
123. 1916—Philip Marvel, Atlantic City, 1856-1938
124. 1917—William G. Schauffler, Lakewood, 1862-1933
125. 1918—Thomas W. Harvey, Orange, 1853-1938
126. 1919—Gordon K. Dickinson, Jersey City, 1855-1930
127. 1920—Philander A. Harris, Paterson, 1852-1924
128. 1921—Henry B. Costill, Trenton, 1860-1935
129. 1922—James Hunter, Jr., Westville, 1866-1931
130. 1923—**WELLS P. EAGLETON**, Newark, born 1865
131. 1924—Archibald Mercer, Newark, 1849-1931. Resigned.
    1924—**LUCIUS F. DONOHOE**, Acting President
132. 1925—**LUCIUS F. DONOHOE**, Bayonne, born 1868
133. 1926—James S. Green, Jr., Elizabeth, 1864-1936
134. 1927—Walt P. Conaway, Atlantic City, 1873-1945
135. 1928—Ephraim R. Mulford, Burlington 1880-1939
136. 1929—**ANDREW F. McBRIDE**, Paterson, born 1869
137. 1930—**GEORGE N. J. SOMMER**, Trenton, born 1874
138. 1931—John F. Hagerty, Newark, 1869-1937
139. 1932—A. Haines Lippincott, Camden, 1867-1937
140. 1933—**FREDERIC J. QUIGLEY**, Union City, born 1883
141. 1934—**LANCELOT ELY**, Somerville, born 1875
142. 1935—**MARCUS W. NEWCOMB**, Browns Mills, born 1880
143. 1936—Francis R. Haussling, Newark, 1875-1941 —resigned
144. 1936—**SPENCER T. SNEDECOR**, Hackensack, born 1900
145. 1937—**WILLIAM G. HERRMAN**, Asbury Park, born 1890
146. 1938—**WILLIAM J. CARRINGTON**, Atlantic City, born 1884
147. 1939—**E. ZEH HAWKES**, Newark, born 1865
148. 1940—**WATSON B. MORRIS**, Springfield, born 1878
149. 1941—**THOMAS K. LEWIS**, Camden, born 1887
150. 1942—Elias J. Marsh, Paterson, 1875-1943
151. 1943—**RALPH K. HOLLINSHED**, Westville, born 1884
152. 1944—**JOSEPH F. LONDRIGAN**, Hoboken, born 1884

**The names of living Fellows are in bold face type.**

## HONORARY MEMBERS

Year of Election

1. 1930—Joseph E. Raycroft, Princeton
2. 1935—Wells P. Eagleton, Newark
3. 1936—Andrew F. McBride, Paterson

Year of Election

4. 1939—Nathan B. Van Etten, New York
5. 1939—Haven Emerson, New York

# An Alphabetical List of the Members of The Medical Society of New Jersey

## COMPILED MARCH 1, 1945

The figures in parentheses refer to County Societies as follows: (1) Atlantic, (2) Bergen, (3) Burlington, (4) Camden, (5) Cape May, (6) Cumberland, (7) Essex, (8) Gloucester, (9) Hudson, (10) Hunterdon, (11) Mercer, (12) Middlesex, (13) Monmouth, (14) Morris, (15) Ocean, (16) Passaic, (17) Salem, (18) Somerset, (19) Sussex, (20) Union, (21) Warren.

**Bold face type indicates members in service**

# A

### ACTIVE MEMBERS

Abbate, Charles C. (2)
Abel, Arthur R. (7)
**Abel, Henri E. (20)**
Abey, William J. H. (11)
Abrams, Abram B. (7)
**Abramson, Solomon (20)**
Ackerhalt, Martin J. (16)
Ackerman, Arthur F. (20)
Ackermann, Edward (14)
Ackley, David B. (11)
Adams, Rayford K. (18)
**Adelman, Benjamin B. (7)**
**Adelman, Nathan (7)**
Adler, Howard E. (12)
Adler, Joseph (9)
Africano, Julius V. (9)
Agayoff, John D. (2)
Agnew, Hobart M. (7)
**Agolia, Michael W. (9)**
Ainsley, H. Bryson (9)
**Aitken, Frank J. (6)**
**Aitken, Herbert M. (19)**
**Albano, Edwin H. (7)**
**Albano, Frank J. (7)**
Albano, Joseph (7)
**Albert, Perry (11)**
Albrecht, William J. (18)
Albright, Louis F. (13)
Alcamo, John H. (7)
Alcaro, Joseph A. (14)
Alexander, Samuel (2)
**Alexander, Stewart F. (2)**
Alexander, Walter G. (7)
**Alford, Ralph I. (7)**
Allan, James S. (7)
Allegrante, Anthony J. (18)
Allen, Arthur A. (16)
**Allen, Chester B., Jr. (7)**
**Allen, Edwin J. (16)**
**Allen, James M. (16)**
**Allen, Samuel L. (20)**
Alling, Frederic A. (7)
Allman, David B. (1)
Alpert, Edward (9)
**Alpren, Bernard F. (16)**
Alter, Nicholas M. (9)
Altman, Charles D. (7)
**Altschul, Frank J. (13)**
Alture, Siegmund S. (20)
Ambrose, Anthony (7)
**Ambrose, Robert R. (18)**
Amdur, Louis A. (9)
Anastor, Herbert C. (6)
Anderson, John F. (12)
Anderson, Reuben M. (2)
**Anderson, Richard D. (3)**
**Anderson, Robert C. (7)**
**Anderson, William A. (7)**
Anderson, William M. (4)
Andrews, Albert G. K. (16)
Andrews, Clarence L. (1)
Andrews, Thomas H. (13)
Andrus, David L. (4)
**Angelillis, Paul (2)**
Angelillo, Marc C. (7)
**Angelo, Joseph A. (9)**
**Angioletti, Louis V. (2)**
Anrig, Grace E. (9)
**Anson, Leon J. (20)**
Anthony, David W. (11)
Antonius, Nicholas A. (7)
**Antopol, William A. (7)**
Anuario, Charles B. (7)
Apfelbaum, Frederick M. (20)
**Applebaum, Irving L. (7)**
Applegate, Edward T. R. (11)
Applestein, Robert (11)
Appleton, Ralph (15)
Appold, George D. (2)
**Apter, Abraham H. (16)**
**Arbeit, Sidney R. (9)**
Arena, John (9)
Areson, William H. (7)
**Aria, Charles J. (9)**
Aria, Michael H. (9)
Armstrong, Lorrimer B. (20)
**Arndt, Frank R. (9)**
Aronis, Harry R. (11)
Aronowitz, Harry T. (9)
**Arons, Harry (7)**
**Artaserse, George V. (9)**
Arthur, Frances H. (20)
**Asbell, Nathan (4)**
Ash, Arthur F. (9)
Ash, Frank W. (16)
Ash, Samuel (7)
Asher, Maurice (7)
Ashley, Harmon H. (11)
**Assante, M. Hugo (4)**
Aszody, Paul (7)
**Athey, Kenneth L. (4)**
Atkinson, James Q. (3)
**Atkinson, John M. (14)**
Atwell, David R. (9)
Atwood, Edward A. (16)
Auerbach, Friedrich (7)
Auriemma, Michele (9)
Austin, Henry J. (11)
**Austin, Thomas R. (20)**
**Averbach, Jacob (16)**
Avery, Philip S. (12)
Axilrod, Maurice H. (1)

### ASSOCIATE MEMBERS

Achtentuch, Herman (16)
Adalson, Edward (7)
Adler, Fritz F. (16)
Adler, Lydia (12)
Autorino, Ralph R. (7)

# B

### ACTIVE MEMBERS

**Babbitt, Hugh M., Jr. (20)**
Bachmann, William (7)
Bacon, Mary (6)
Bacote, Ernest F. (7)
Baeseman, R. Winfield (13)
Bagg, Linus W. (7)
**Bahnson, Conrad M. (9)**
Bailyn, Emanuel (9)
**Baime, Jules E. (7)**
**Balocchi, Pascal J. (7)**
Baker, Augustus L. (14)
**Baker, Banks S. (4)**

Baker, Elsworth F. (13)
Baker, Hugh W. (6)
Baker, Maclyn F. (7)
Baker, Maurice E. (4)
Baker, Philip W. (10)
Baker, Raymond D. (20)
Baketel, H. Sheridan (2)
Baldauf, Herman, Jr. (21)
**Baldwin, John F. (2)**
Baldwin, Samuel H. (7)
**Ballard, William C. (14)**
**Balles, Edward S. (16)**
Ballinger, Reeve L. (9)
**Balogh, William A. (12)**
Balsamo, Anthony J. (9)
**Balsamo, Joseph J. (7)**
**Balson, Zachary D. B. (7)**
Balze, Henry R. (2)
**Bambara, Aurelius J. (10)**
Banker, George T. (20)
**Banta, Raymond E. (2)**
**Bar, Samuel (13)**
Barb, Kirk B. (4)
**Barbano, Alfred J. (12)**
Barbarito, William N. (9)
Barbash, Roslyn H. W. (2)
Barbash, Samuel (1)
**Barbella, Joseph D. (7)**
Barberio, A. Arthur (20)
**Barbour, George E. (18)**
Barishaw, Samuel B. (9)
**Barkhorn, Charles W. (7)**
Barkhorn, Henry C. (7)
**Barlow, Frank A. (16)**
**Barlow, G. Barton (2)**
**Barlow, John D. (11)**
**Barnard, Frank G. (7)**
Barnes, William J. (2)
Barnett, Lester A. (12)
**Barnshaw, Harold D. (4)**
**Barolsky, Benjamin (16)**
Baron, Herbert A. (2)
Baron, Leo E. (20)
**Barone, Francis A. (9)**
**Barr, Joseph (16)**
Barrett, John E. (7)
**Barrett, Joseph F. (7)**
**Barroway, James N. (4)**
Barrows, Arthur M. (11)
Barrows, Victor I. (8)
Barry, R. Grant (11)
Bartlett, Clara K. (1)
Barton, Amy S. (3)
Baruch, Hilde (20)
**Baruch, Rudolf J. (20)**
Bassett, Lavern C. (12)
Bassett, Norman H. (1)
**Battaglia, Richard S. (20)**
Baum, Felix (7)
Baum, Samuel (7)
**Bauman, Everett O. (7)**
Bauman, Kenneth R. (6)
Bauman, Rush C. (7)
Baxt, Sidney J. (16)
**Bayne, Joseph K. (11)**
Beairsto, Everett B. (11)
Beatty, Hannah J. (10)
Beaver, Jennie D. (14)
Bechet, Paul E. (20)
Becker, C. Frederick (4)
Becker, Frank F. (16)
**Becker, George L. (16)**
Becker, Leo V. (16)
**Becker, Martin (7)**
Becker, Sidney D. (13)
Beer, Sanel (7)
Behrens, Herman H. E. (9)
Beideman, Casper M. (4)
Beir, Ily R. (1)
Beisler, Lawrence G. (20)
**Belafsky, Henry A. (12)**
**Belfer, Jacob J. (11)**
Belford, Ralph J. (11)
Beling, C. Abbott (7)
Beling, Christopher C. (7)
Bell, Horace O. (7)
Bell, Thomas (7)
Bellak, Ellis R. (6)
Bellis, Horace D. (11)
Belott, Louis V. (7)
Ben-Asher, Solomon (9)
Bender, Dorothea A. (20)
**Bender, Louis (7)**
Bender, Theodore (16)
Bengelsdorf, Aron (7)
Benjamin, Harold C. (9)
**Benjamin, Joseph F. (16)**
**Bennett, Robert E. (11)**
Bennett, William F. (7)
Bensley, Maynard G. (20)
Bentley, David F., Jr. (4)
**Benz, Francis J. (14)**
Berardinelli, Carmine G. (7)
**Berenson, Samuel J. (20)**
Beres, Albert J. (2)
**Berg, Samuel (7)**
Berger, William A. (7)
Bergin, Joseph V. (16)
Bergman, Meyer W. (7)
**Bergmann, Ewald H. (19)**
**Bergsma, Daniel (11)**
**Berk, M. David (16)**
Berke, Raynold N. (2)
Berkhout, Peter G. (16)
**Berkow, Samuel G. (12)**
Berkowitz, Benjamin (6)
Berlin, Joseph I. (9)
**Berlin, Morris R. (7)**
Berman, H. Robert (7)
Berman, Jacob J. (11)
Berman, Leonard M. (20)
**Berman, Sol (20)**
**Bernard, Richard C. (2)**
**Bernhard, William G. (7)**
**Bernheisel, Louis E. (5)**
Bernson, Samuel T. (16)
Bernstein, Arthur (7)
**Bernstein, Benedict J. (20)**
Bernstein, Julius (7)
Berry, C. Hartley (20)
Berry, Leonard M. (11)
**Bertha, Nicholas A. (14)**
Beshlian, Hagop K. (16)
Besson, Franklin J. (7)
**Betancourt, Raul R. (4)**
**Betcher, Albert M. (9)**
**Betts, R. Winfield (3)**
**Bew, Richard C. (1)**
Beyer, Othmar J. (7)
**Beyer, William (2)**
Bianchi, Angelo R. (7)
Biber, David (20)
Biczak, Arkad K. (16)
Bien, Frank A. (7)
Bierach, Jules L. (15)
Bigelow, Elizabeth F. (7)
**Bigelow, Nelson S. (7)**
**Bigliani, Urban R. (9)**
**Binder, Charles I. (7)**
Binder, Joseph (13)
Bird, Frank L. (14)
Birdsall, Clarence A. (7)
Birrell, Russell G. (20)
Bishop, Carl (20)
Bissett, John V. (7)
Bitten, Robert M. (9)
**Biunno, Anthony J. (7)**
Black, LeRoy W. (2)
**Black, Maskell B. (8)**
**Black, Max S. (20)**
Blackburne, George (7)
Blackwell, Enoch (11)
Blair, Thomas D. (20)
**Blaisdell, C. Byron (13)**
**Blake, Albert J. (16)**
Blakey, Abram P. (9)
Blanchard, Charles L. (14)
Blanchard, Kenneth (7)
**Blank, Samuel (18)**
**Blatt, David (20)**
Blaugrund, Samuel (11)
Blaustein, Maurice L. (7)
Blauvelt-Wells, Grace B. (2)
Bleasby, Charles B. (2)
**Bleiberg, Jacob (7)**
**Blenkle, Victor A. (2)**
Bloch, Harry (20)
Block, Marcus T. (7)
Block, Max (7)
**Block, Milton (7)**
Bloom, G. Homer (21)
Blum, Joseph M. (11)
**Blum, Milton (9)**
Blumberg, Jack (20)
Blythe, Rowland P. (20)
**Bobadilla, Juan E. B. (14)**
**Bocchini, Joseph A. (7)**
Bohl, Louis J. (16)
Bokor, Emery (7)
Boland, Lucy E. (9)
**Bolanowski, Kasimier J. (20)**
Bolten, Bernard (7)
**Bonanno, Peter J. (9)**
Bongiorno, Henry D. (16)
**Bonnet, W. Laurence (11)**
Bono, Joseph J. (2)
Bonomo, Michael J. (7)
**Bookrajian, Edward N. (9)**
Bookstaver, Barnet S. (2)
Booth, George R. (8)
**Booth, Walter S. (20)**
**Booth, William K. (14)**
Boothby, I. Roland (10)
**Boquist, Walter A. (21)**
Bornstein, David (16)
**Bornstein, Paul K. (13)**
Borow, Benjamin (18)
Borow, Henry (18)
**Borow, Louis S. (18)**
Borow, Maurice (18)
**Borrella, Dominic D. (11)**
Borrone, Milton G. (9)
**Borshaw, Hyman (9)**
**Borsher, Irving P. (7)**
Bortone, Frank (9)
Bosch, Taeke (2)
**Boselli, Emile H. (9)**
Bossard, Harry B. (21)
Bossone, Joseph E. (13)
Bostwick, Delazon S. (6)
Bostwick, Wallace R. (21)
Botbyl, Burt W. (16)
Botti, John A. (9)
**Bourns, Edward G. (20)**
Bove, Joseph (7)

**Bowen, Robert N. (4)**
Bowers, F. Clyde (14)
Bowersox, Clarence A. (8)
Bowles, Harry H. (20)
**Bowman, Ned O. (12)**
Boyd, John B. (13)
**Boyd, Robert P. (20)**
Boyd, William B., Jr. (19)
Boyer, Charles G. (10)
**Boyer, Paul K. (20)**
Boyers, Sidney S. (9)
Boyes, James G. (20)
Boylan, Lawrence B. (16)
**Boyle, Francis L. (9)**
Boysen, Theophilus H. (1)
**Boyt, Theodore (12)**
Brackett, Elizabeth R. (7)
**Bradasch, George A. (9)**
Bradford, Stella S. (7)
Bradley, Robert A. (1)
Brady, Raymond J. (7)
Brady, Thomas S. (9)
Brady, William A. (9)
Braitman, Max (9)
Brakeley, Elizabeth (7)
Bramble, Halsey S. (17)
Brams, William M. (7)
**Brancone, Alphonse M. (16)**
**Brandman, Otto (7)**
Branin, Howard S. (6)
**Branon, Mark E. (2)**
Brasefield, Edgar N. (21)
**Brauer, Selig L. (9)**
**Braun, David C. (19)**
**Braun, Edgar M. (20)**
Braun, Gustav A. (7)
Braun, Joseph C. (2)
Braun, William (4)
Braunstein, Sigmund C. (9)
Braunstein, William P. (9)
Braunwarth, Robert J. (20)
Bray, William E. (3)
Bregman, Alexander (2)
Bregman, Milton (13)
Breitstadt, Charles A. (7)
**Bremer, Kenneth M. (7)**
Brennan, Alfred T. V., Jr. (2)
Brennan, Charles L. S. (4)
Brennan, John P. (4)
Brennock, Thomas McG. (9)
**Bresev, Morris (9)**
**Breslow, Alexander E. (20)**
Breslow, Samuel (12)
Brethwaite, Samuel H., Jr. (20)
Brick, George J. (9)
Brien, William M. (7)
Briggs, Henry (7)
**Brignola, Gerald C. (9)**
Brim, Anne S. (7)
Brindle, Harry R. (13)
Brittain, Elmore G. (18)
Broadnax, Mary E. (7)
Brodkin, Eva T. (7)
**Brodkin, Henry A. (7)**
**Brodkin, Louis A. (7)**
Brody, Morton S. (12)
**Brogan, Francis B. (16)**
Brokaw, Christopher A. (20)
Bromberg, Charles B. (16)
**Brooke, Charles R. (7)**
Brooks, George M. (5)
Brooks, Sidney S. (16)
Brophy, Francis X. (9)
**Broselow, Benjamin G. (8)**
**Brotman, Harry (7)**
Brotman, Morton M. (7)
Brown, Chester R. (7)
Brown, Chester T. (7)
Brown, Edith L. (13)
Brown, Edward V. (7)
Brown, Frank H., Jr. (20)
Brown, Frederick L. (12)
Brown, Harold W. (7)
Brown, J. Carlisle (1)
**Brown, John L. (2)**
Brown, Kenneth G. (13)
Brown, L. Greeley (20)
**Brown, Leonard (2)**
**Brown, Lewis W. (7)**
**Brown, Stanley L. (4)**
Brown, William H. (20)
Browne, George F. (7)
Browning, William J. (4)
Brozdowski, John J. (9)
**Brozyna, Mieczyslaw (2)**
**Bruning, Richard H. (7)**
Brunkow, Charles D. (7)
**Buchanan, Ralph M. L. (21)**
Buchanan, Robert W. (20)
**Buckley, Jeremiah L. (7)**
Buckley, Paul J. (2)
Buckley, Richard T., Jr. (11)
Buckner, Roscoe W. H. (7)
Budd, J. Reuben (16)
Buermann, August, III (7)
Buermann, Robert (15)
**Buffey, Walter H. (20)**
Bull, Louis M. (7)
Bull, William J. (7)
Bullen, Victor E. (16)
**Bump, Samuel C. (2)**
Bunnell, Frederick N. (15)
**Burbidge, J. Raymond (11)**
Burke, Leonard P. (7)
Burke, Stephen E. (7)
**Burkett, J. Paul (8)**
Burkett, Wendell J. (8)
Burkhead, Howard C. (13)
Burn, Victor E. (19)
Burne, John J. (7)
Burnham, Lyman (2)
Burns, Geoffrey C. H. (2)
Burns, Joseph R. (11)
**Burns, Wilmer F. (4)**
**Burpeau, William P. (7)**
**Burrill, Benjamin B., Jr. (7)**
Burritt, Norman W. (20)
**Burroughs, Edmund W. (11)**
Burrus, Thomas P. (7)
**Burstein, Frank (7)**
Burstein, Leo Q. (7)
Burstein, Rachel (7)
Busansky, Samuel T. (3)
Busch, Herman (7)
Bush, Archer C. (7)
Bush, Ralph K. (4)
Busicco, Philip S. (2)
**Butan, Louis (7)**
Butcher, Charles (6)
**Butenas, Joseph J. (20)**
Butler, Samuel S. (4)
Butler, Vincent P. (9)
Butterfield, Arey A. (16)
Buvinger, Charles W. (7)
**Byck, Louis (7)**
**Byer, M. Yale (11)**
Byrne, J. Arthur (14)
Bythewood, Alton E., Jr. (7)

ASSOCIATE MEMBERS

Berney, Irving (7)
Berney, Ruth V. (7)
**Bernstein, Bertram (11)**
Biggar, Raymond W. (13)
Booth, Herbert W. (13)
**Boudwin, Norman K. (11)**
Brewer, Catherine H. (7)
Bronner, Alfred (16)
Buchholz, Alexander (2)
Burokus, William (2)

# C

ACTIVE MEMBERS

Cacciarelli, Robert A. (7)
**Caggiano, Anthony P. (7)**
Caggiano, John D. (17)
Cahill, Laurence A. (7)
**Calasibetta, Charles J. (7)**
**Caldwell, Donald M. (7)**
Caldwell, Julius A. (7)
**Caleca, Jack J. (19)**
**Callahan, Edward J. (20)**
Calligaro, Egildo A. (16)
**Calvert, William C. (7)**
Calvin, Charles H. (12)
Camche, Leo J. (7)
Cameron, Arthur E. (7)
**Cameron, C. Paul (5)**
Cameron, Edwin A. (7)
Campana, Francis A. (9)
Campana, Vincent R. (9)
Campbell, Everette L. (7)
Campbell, James M. (2)
Campbell, William (7)
Campo, A. Guy (8)
**Candio, Vincent P. (2)**
Cangemi, Vito F. (9)
Cannis, John P. (20)
Cannon, Edward A. (9)
Canright, Cyril M. (20)
Cantalupo, Emidio (7)
Cantelmo, Alphonse L. (7)
Cantini, Raphael S. (20)
Capell, Harry H. (16)
Capio, Mario D. (16)
**Caprio, Orlando G. (7)**

**Captanian, Aram A. (13)**
Caputo, Anthony R. (7)
**Carabelli, A. Albert (11)**
Carbone, Francesco N. (7)
**Carbone, Ralph (2)**
Card, Charles F. (20)
Cardinale, Pasquale F. (20)
**Cardwell, Edgar P. (7)**
Carey, David S. (13)
Caridi, Salvatore (9)
Carlander, Oswald R. (4)
Carlisle, J. Mallory (20)
Carlisle, John H. (16)
Carlisle, Paul E. (7)
Carlough, David J. (16)
Carman, Fletcher F. (7)
Carmona, L. Roberto (15)
**Carpenter, Cedric C. (20)**
Carpenter, Charles A. (7)
Carpenter, William H. (8)
Carr, Alexander M. (12)
Carr, Josephus C. (7)
Carr, Mary B. (9)
**Carrigan, Francis P. (7)**
**Carrington, William J. (1)**
Carrol, Wilfred (7)
Carroll, C. Walter (11)
**Carroll, Thomas R. (2)**
Carroll, William V. (11)
**Carsley, Sidney H. (20)**
Carter, Joseph F. S. (13)
**Cartisser, Joseph J. (19)**
Cartnick, Louis C. (2)
**Caruso, Paul F. (2)**
**Casagrande, Stephen R. (13)**
Casale, John B. (7)
**Casciano, Adolph D. (2)**
Casey, Robert B. (20)
Casilli, Arturo R. (20)
Casselman, Arthur J. (4)
Cassini, Henry C. (7)
Castaldo, Neil (20)
Castellano, Martin G. (7)
Catania, Joseph P. (2)
Catanzaro, Francesco (16)
Catlaw, J. Kenneth (9)
Cella, Charles F. (11)
**Cerone, Daniel M. (7)**
Cerreto, Frank R. (7)
Cestone, Canio (7)
**Chaiken, Louis H. (20)**
**Chalfant, W. Paxson, Jr. (1)**
Chalfant, William P. (8)
Chamberlain, Aims R. (7)
Chamberlain, Richard R. (7)
Champlin, Paul M. (7)
Chapman, Ellis J. (9)
Chapman, Otis P. (20)
**Chapman, Walter I. (16)**
Chapnick, Maurice M. (16)
**Charleroy, Durant K. (11)**
Charlton, C. Coulter (1)
**Charney, William (16)**
Chase, Kalman, Jr. (2)
Chattin, J. Franklin (7)
Chayes, Sydney (9)
Cherashore, Harry N. (7)
**Chernus, Jack (7)**
Cherry, Homer H. (16)
**Cheskin, Louis J. (7)**
Chesler, Maurice (17)
Chesner, William A. (11)
**Chesnick, Reuben B. (4)**
Chester, Saul W. (16)
Chianese, C. Chester (11)
Chiger, Alexander S. (7)
Childers, Robert J. (20)
**Chilton, Forrest S. (16)**
**Chimacoff, Hyman (7)**
**Chmelnik, Abraham G. (7)**
**Chodosh, Maurice A. (20)**
Choffy, Sylvester A. (9)
Chrisman, Irving (16)
Christensen, Alexander H. (10)
Christensen, Osborne D. (2)
**Christian, Henry A. (9)**
**Christoph, Francis T. (7)**
**Churg, Jacob (16)**
Ciccone, Anthony C. (16)
**Ciccone, Edwin L. (7)**
Cieri, Daniel S. (9)
Ciliberti, Frank J., Jr. (4)
**Clarie, D'Arcy C. (2)**
Clark, Alice L. (11)
Clark, Ernest W. (4)
Clark, Frank G. (10)
**Clark, John C. (13)**
**Clark, Orlo H. (16)**
Clark, S. Worth (1)
Clarke, Edward W. (2)
Clarke, Francis M. (12)
Clarke, R. Manning (4)
Clarken, Joseph A. (7)
Claus, C. Hermann (7)
Cleary, Joseph P. (1)
**Clement, Baxter L. (7)**
**Clement, John B. (3)**
**Clinton, Joseph A. (7)**
**Close, Byron H. (16)**
Cloud, Albert W. (2)
**Coburn, J. Wesley (7)**
**Coffin, Henry F. (7)**
Coghlan, Jasper (7)
Cohan, Charles C. (11)
Cohan, Joseph (11)
Cohen, Harry X. (20)
Cohen, Herman (9)
**Cohen, Herman (11)**
Cohen, Herman N. (9)
Cohen, I. Elvin (7)
Cohen, Julian (16)
Cohen, Louis (16)
**Cohen, M. Marvin (16)**
Cohen, Maurice (7)
Cohen, Maurice B. (5)
Cohen, Max (7)
Cohen, Meyer J. (7)
Cohen, Oscar H. (14)
**Cohen, Paul (4)**
**Cohen, Samuel (9)**
**Cohen, Samuel A. (9)**
**Cohen, Sidney A. (7)**
Cohen, Sidney L. (7)
**Cohen, Sidney P. (7)**
**Cohen, William (11)**
Cohn, George M. (7)
Cohn, Hermann (7)
Cohn, Isidor (16)
Cohn, Royal M. (7)
**Colavita, James J. (11)**
**Colby, Maxwell X. (13)**
**Cole, L. Frank (16)**
**Cole, Nathaniel B. (12)**
Cole, Walter H., Jr., (20)
Coleman, Austin H. (10)
Coleman, Joseph G. (19)
**Coleman, Russell M. (7)**
Collier, Martin H. (4)
Collins, Henry J. (11)
Collins, Laurence M. (14)
**Collins, Louis K. (8)**
**Colmer, M. Jonas (7)**
Colsh, LeRoy L. (7)
**Colton, Ethan T., Jr. (7)**
Comando, Harry N. (7)
Comeau, George W. (14)
Comfort, John B. (11)
Commini, Frank F. (11)
Comunale, Anthony R. (20)
Conlen, Richard (4)
Connamacher, Harold S. (7)
**Connell, Emmet J. (9)**
Connell, John N. (9)
Connolly, John J. (7)
**Connolly, Joseph P. (16)**
Connolly, Richard N. (7)
Connolly, Thomas W. (9)
Connor, Clarence A. (2)
Conroy, John S. (3)
**Conserva, Peter V. (16)**
Conti, Michael (9)
Conty, Anthony J. (9)
**Conway, James V. (20)**
Cook, Dora G. (14)
Cook, Hugh F. (7)
**Cooley, Justus H., II (18)**
Cooper, David P. (7)
Cooper, Howard M. (2)
Cooper, Irving J. (12)
Cooper, Jules (5)
**Cooper, Robert A. (4)**
Cooperman, Eli L. (12)
**Copleman, Benjamin (12)**
**Copleman, Hyman B. (12)**
Coplin, George J. (20)
**Coppoletta, Joseph M. (2)**
Corbusier, Harold D. (20)
Cordasco, Peter (7)
Corio, George A. (11)
Corn, David (2)
**Cornish, Charles H. (7)**
Cornwell, Alfred (6)
Corrigan, Patrick H. (11)
Corson, Filbert R. (1)
**Corson, Kenneth E. (6)**
Cortese, Alvin E. (16)
Corwin, Emanuel M. (14)
**Cosgrove, Robert A. (9)**
Cosgrove, Samuel A. (9)
**Costa, Philip L. (13)**
Costello, William F. (14)
**Cotton, Henry A., Jr. (11)**
Cotton, Norman T. (16)
Cottone, Rosario J. (11)
Cottrell, Judson G. (12)
Coughlan, Ella A. (7)
Coughlin, Frank J. (7)
**Coughlin, John P. (9)**
**Coughlin, Joseph J. (2)**
Coultas, Aldo B. (14)
**Covino, Louis L. (7)**
**Cowan, Joseph H. (9)**
Cowlbeck, Harry D. (11)
Cox, Harold C. (11)
**Cox, J. Robert (17)**
Cox, John C. (7)
**Cox, William T. R. (20)**
Cox, William W. (7)
**Coxson, Harold P. (4)**
Crabtree, Loren H. (20)
Cracco, Frederick A. (9)
Craig, Henry A. (18)
Crandall, John K. (2)
**Crandell, C. Archie (14)**
Crane, Bernard (1)

Crane, Charles G. (7)
**Crane, Norman T. (20)**
Crane, Percy R. (14)
**Crane, Reynold M. (4)**
Crapanzano, Domenico (7)
Craster, Charles V. (7)
Crawford, Georgina U. (7)
**Crawford, John W. (18)**
Crecca, Anthony D. (7)
Crecca, William D. (7)
Cregar, John S. (7)
Cremens, John F. (16)
Crescente, Fred J. (16)
**Cricco, Carl F. (9)**
**Crist, Walter A. (4)**
**Cronin, Francis J. (20)**
Crooks, William J., III (10)
Cropsey, Charles D. (2)
Crossfield, Henry C. (7)
Crounse, David R. (16)
Crowe, Aldrich C. (5)
Crowley, Joseph W. (4)
**Cryder, Millard C. (5)**
Crysteli, Edward H. (7)
Csema, Emery J. (12)
Ctibor, Vladimir F. (10)
Cufarl, Carmine J. (9)
Culver, S. Herbert (9)
Cummins, Ella F. (14)
**Cunningham, Charles, Jr. (6)**
**Cunningham, Joel B. (4)**
**Cuono, Joseph D. (2)**
**Cupaiuoli, Richard A. (9)**
Curry, Marcus A. (14)
Curtis, A. Maurice (16)
Curtis, Arthur W. (7)
**Curtis, Donald A. (2)**
Curtis, Elbert A. (7)
Curtis, Howard C. (3)

ASSOCIATE MEMBER

Cannata, Benjamin (12)
**Chudzik, Edward W. (16)**
Clark, Margaret A. (2)

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# D

ACTIVE MEMBERS

D'Acierno, Pellegrino A. (9)
**D'Addario, Anthony R. (7)**
D'Agostin, Henry (2)
**D'Agostini, Alfred J. (7)**
**D'Agostini, Robert J. (7)**
D'Alessandro, Arthur J. (7)
Dalton, S. Eugene (1)
Daly, Edmund J. (9)
**Daly, John F. (2)**
**D'Amato, Charles R. (2)**
D'Ambola, Philip R. (7)
D'Amico, Thomas V. (7)
Dandois, George F. (5)
Dane, Charles (7)
Dane, John (7)
D'Angelo, Joseph C. (7)
**Danielson, John J. (9)**
**Dann, Frederick J. (7)**
**Dante, Pasquale (7)**
**Danzis, Louis (7)**
Danzis, Maximillian (7)
Darby, C. Eugene (5)
**Darby, I. Kermit (7)**
D'Arcy, Walter E. (11)
Darden, Walter T. (7)
Darlington, Emlen P. (3)
Daron, Simeon (7)
Davenport, Irwin P. (11)
Daversa, Benjamin (13)
**David, Leopold S. (4)**
Davidson, E. Norwell (20)
Davidson, Harold S. (1)
**Davidson, Henry A. (7)**
Davidson, Maurice M. (20)
Davies, George A. (6)
Davies, George W. (7)
Davis, A. Hobson (16)
Davis, Albert B. (4)
Davis, Clarence E. (8)
**Davis, Daniel (9)**
**Davis, E. Vernon (3)**
Davis, F. Cleveland (20)
Davis, Harold L. (11)
Davis, J. Stannard (4)
Davis, Jacob M. (3)
**Davis, John E., Jr. (11)**
Davis, Louis (7)
Davis, Stanton H. (20)
**Davis, Thomas C. (7)**
Davis, William J. (7)
**Davison, C. Spencer (17)**
Davison, Royden W. (11)
Davison, Wilbur S. (17)
**Dawson, Harry (16)**
**Day, Hayward F. (18)**
Day, Samuel T. (6)
Day, Willis B. (20)
Dayton, Spencer T. (2)
Dean, Guy K., Jr. (11)
Dear, Abraham L. (7)
DeBell, Peter J. (16)
**DeBiaso, Cornellus V. (2)**
DeCesare, Ferdinand J. (20)
Decker, Charles T. (20)
Decker, Frederick H. (10)
Decker, Henry B. (4)
Decker, John G. (2)
**DeFeliee, Mario T. (14)**
DeFronzo, Morando (7)
DeFuccio, Charles P. (9)
**DeFusco, G. Thomas (9)**
**Degenhardt, Ira H. (12)**
**DeGerome, James H. (7)**
**DeGrace, Francis H. (16)**
deHellebranth, Roland T. (1)
Deibert, Irvin E. (4)
Deich, Samuel R. (16)
**Deichman, Charles H. (14)**
Deignan, William L. (7)
Deitmaring, Francis A. (9)
**Deitz, Joseph R. (11)**
Delaney, Oscar M. (7)
Delario, Anthony J. (16)
**Del Baglivo, Mario (9)**
Delcau, Jules (13)
Del Deo, Nicholas V. (7)
**Del Duca, Vincent P. (4)**
DeLeonardis, James V. (7)
Del Guercio, Olindo (7)
**DeLia, Emilio (7)**
**Del Mauro, Alphonse (16)**
**Del Negro, Albert E. (7)**
**DeMarco, Silverino V. (9)**
**Demarest, Gerald B. (20)**
Demarest, J. Willis (2)
DeMattia, Michael (16)
**Dembinski, T. Henry (11)**
**DeMichele, Roland V. (7)**
**Dempsey, J. Harvey (4)**
**Denbo, Elie A. (4)**
Denelsbeck, J. Otis (11)
Denes, Oscar (7)
Dengler, Henry P. (20)
Denig, Ralph D. (2)
**Denison, Ward C. (2)**
**DePalma, Anthony F. (7)**
DePhillips, Benedict R. (7)
dePons, Sarah C. (13)
**DeRosa, Armand (16)**
DeRosa, Louis (14)
**DeSantis, Orazio J. (6)**
DeSanto, Anthony M. (2)
DeSevo, Gerard E. (9)
Desmet, Victor F. (16)
Dessauer, Joseph (7)
Detrano, Salvatore J. (9)
**DeTrola, Frederick C. (7)**
**Deuell, William D. (2)**
**Deutel, Oscar R. (7)**
**Deutsch, Nathan S. (20)**
DeVincentis, Henry (7)
DeVincenzo, F. Richard (9)
DeVita, Anthony J. (13)
**Devlin, Arthur D. (7)**
Devlin, Hugh J. (7)
Dewis, Edwin G. (13)
Dexter, Harriet E. T. (9)
**DeYoe, Leon E. (16)**
Dezer, Charles N., Jr., (2)
Diamond, David I. (13)
Diamond, J. George (20)
Dias, Joseph L. (7)
Dickson, John D. (2)
Dickson, T. Bruce (3)
Dieffenbach, Richard H. (7)
**Dieker, Howard E. (12)**
**Diener, Samuel (7)**
**DiFino, Felix J. (7)**
DiGiacomo, Harry E. (7)
**DiGiacomo, William H. (7)**
**DiIelsi, Anthony J. (4)**
Diiger, Frederick G. (2)
DiMarino, Anthony J. (8)
Dimitrow, Helen (13)
**Dimun, John T. (11)**
Dinge, Ferdinand C. (7)
Dingman, Norman M. (16)
**DiNicolantonio, Vincent J. (1,**
**DiNorcia, Joseph (7)**
**Diskin, Samuel M. (1)**

Diverty, Henry B. (8)
**Dochtermann, Warren P. (14)**
Dodd, Edward L. (7)
Dodd, William E. (15)
**Dodge, James T. (11)**
Doggett, E. Hugh (20)
**Doktor, David (16)**
Dolsky, Irving (20)
Donahue, William J. (7)
Donchi, Sol M. (7)
Donges, Clarence B. (4)
**Donnelly, John H. (7)**
**Donnelly, Joseph E. (16)**
Donnelly, Joseph P. (9)
**Donnelly, William A. (1)**
Donohoe, Lucius F. (9)
Donohue, Daniel J. (9)
Doody, William M. (9)
**Doran, Ralph J. (9)**
Doran, William G. (9)
**Doranz, Harold K. (11)**
Dorr, Henry B. (13)
**Dougherty, Daniel D. (9)**
Douglass, Stephen A. (16)
Douglass, William C. (18)
**Dow, Robert F. (16)**
Dowds, Samuel C. (7)
Downing, Perley E. (12)
**Downs, Louis S. (12)**
Downs, Roscius I. (3)
**Doyle, George F. (2)**
Doyle, John J. (9)
Dragonetti, Elvige N. (7)
Drake, Daniel E. (16)
Drake, Leo B. (19)
Drake, Paul F. (21)
Dranow, Paul (7)
Drapkin, Berta (7)
Dredge, Thomas J. (14)
Dreskin, Jacob L. (7)
Drezner, Henry L. (11)
**Driscoll, Charles D. (4)**
**Driscoll, Raymond S. (9)**
**Drossner, Jacob L. (4)**
DuBois, Morris G. (7)
duBusc, L. C. Victor (20)
Duckett, Warren J. (9)
Duffy, Edward P., Jr. (7)
**Duisberg, Richard E. H. (2)**
Dukes, Howard R. (9)
Dulany, Theodore L. (7)
Dulin, Everett V. (7)
Duncan, Owsley B. (16)
**Dunham, Malcolm M. (12)**
**Dunn, H. Irving (20)**
**Dunn, John S. (17)**
**Dunn, Theodore B. (7)**
Dunning, Walter L. (16)
Dupuy, Jean G. (20)
Durchlag, E. Nelson (7)
**Durham, Robert B. (1)**
Durham, Royal E. (1)
Durrah, Fred F. (20)
Duschock, Edward F. (12)
Duvall, Albert I. (13)
Dwork, Harold K. (7)
**Dwoyer, Leon C. (20)**
Dwyer, Henry E. (16)
Dwyer, William A. (16)
**Dyer, Edward H. (1)**

ASSOCIATE MEMBERS

Demaree, Richard H. (13) Dzienis, John (11)

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# E

ACTIVE MEMBERS

Eadie, Gordon (20)
Eagleton, Wells P. (7)
**Eames, William N. (11)**
Earp, Ruth (14)
Eason, Samuel W. (20)
**East, Isaac C. (12)**
Ebenfeld, Samuel W. (7)
**Ebner, Paul G. (4)**
Echikson, Joseph I. (7)
Eck, Daniel B. (7)
Eckert, Walter L. (1)
Eckhardt, Ralph A. (14)
**Eddy, Lester R. (19)**
Edelberg, Sidney S. (18)
Edelen, James J. (7)
**Edelson, Samnel (13)**
Edgar, Malcolm S. (20)
**Edgerly, Sherburn E. (2)**
**Edlkraut, Edward C. (16)**
Edwards, J. Bennett (2)
Edwards, Lena F. (9)
Ehrenfeld, Edward (16)
Ehrenfeld, Irving (16)
Ehrlich, Edward (7)
**Ehrlich, Max (20)**
Ehrlich, William E. (7)
Ehrlich-Morrow, Laura E. (2)
Eichler, Bernard B. (7)
**Eigen, Louis A. (7)**
Ein, William B. (7)
**Einhorn, Samuel E. (7)**
Eisenberg, David S. (7)
Eisenhower, J. S. D. (5)
Eisenstodt, Lester W. (7)
Ekings, Frank P. (16)
**Elias, Elmer J. (11)**
Ellenson, Solomon S. (13)
**Elliott, Frazier J. (1)**
Ellis, Alexander (4)
Ellis, Arthur J. (7)
Ellmers, Basil J. (2)
Elsasser, Theodore H. (9)
Elwood, Benjamin J. (9)
Ely, Lancelot (18)
Emerson, Linn (7)
Emmer, S. Wolfe (7)
**Emory, George B., Jr. (14)**
**Engelhart, Ferdinand K. (11)**
Englander, Charles (7)
**English, Harrison F., III (11)**
English, John T. (7)
English, Samuel B. (10)
Enright, James G. (9)
Epler, Don A. (7)
Epstein, Harry B. (7)
Epstein, Rubie (11)
**Epstein, William M. (7)**
**Erber, Leonard B. (1)**
**Erdman, George L. (7)**
**Erler, Robert E. (7)**
Ernest, Richard B. (11)
Ernst, Philip A. (1)
Ervin, Millard B. (7)
Esposito, Amedeo C. (14)
**Esposito, Anthony L. (16)**
Esposito, Antonio L. (1)
Essertier, Edward P. (2)
Essertier, Harland C. (2)
**Esty, Geoffrey W. (20)**
**Etheridge, Charles H. (7)**
Ettinger, Samuel (9)
Eulner, Elmer H. (12)
Evans, Charles H. (7)
**Evans, David P. (7)**
Evans, Edgar E. (17)
**Evans, Edgar J. (14)**
Evans, J. Lawrence (9)
**Evans, J. Lawrence, Jr. (2)**
Evans, Joseph O. (20)
Ewens, Arthur E. (1)
Ewing, Harvey M. (7)
Ewing, Leslie H. (4)
**Eynon, Harold K. (4)**
**Eynon, James R. (4)**

ASSOCIATE MEMBERS

Edelson, Edmond (7) Edwards, Walter R. (11)

# F

## ACTIVE MEMBERS

**Faber, Edward (9)**
Fabian, Paul L. (11)
Facciolo, Frank (9)
**Fader, Ferdinand (7)**
Fagan, James L. (12)
**Fager, Rudolph O. (7)**
Fahrenbruch, Frederick D. (3)
Failing, Brayton E. (7)
**Failmezger, Theodore R. (14)**
Faison, John B. (9)
**Falcone, Nicholas A. (18)**
Falconer-Slater, Katherine (20)
**Falkinburg, LeRoy W. (15)**
Falvello, Nicholas A. (14)
Fanburg, Sol J. (7)
Fanelli, Antonio (12)
Farkas, Gustav (16)
Farkas, Morris (7)
Farmer, Vincent (2)
Farmer, Walter D. (11)
Farr, Irving L. (7)
**Farr, Walter J. (2)**
**Farrell, Edgar A. H. (4)**
Fasano, Giovanni (7)
**Fattel, Henry C. (9)**
Faughnan, Rose C. (7)
Faulkingham, Ralph J. (12)
Fauquier, Leonard B. (9)
**Faux, Frederick J. (8)**
Fava, Philip V. (7)
Fazio, Vincent J. (13)
**Featherston, Daniel F. (13)**
Fechner, Julius (7)
**Federer, John J. (9)**
Feher, Ladislas A. M. (12)
Feigenoff, Israel (16)
Fein, Bernard (7)
**Feinberg, Harry (9)**
**Feinberg, Harry D. (13)**
Feinsod, Samuel N. (7)
**Feldman, Frank H. (7)**
Feldman, Joel (13)
Feleppa, Edward E. (20)
Felitti, Vincent J. (9)
**Feller, William (9)**
Feman, J. George (13)
Fendrick, Edward (7)
**Fenichel, Benjamin (7)**
**Fenimore, Edward D. (9)**
Fenster, Morton N. (16)
**Fenton, Tennant E. (13)**
Fenwick, John R. (16)
Ferguson, William E. (7)
Fermaglich, Harry B. (2)
Fern, Samuel S. (7)
Ferrari, Andrew F. (2)
Ferrary, Paul B. (16)
Ferriss, Ruth B. (14)
Fessler, A. James (11)
Fessler, William (2)
**Fessman, John W. (4)**
Feuer, Joseph A. (7)
**Fialk, Harry (9)**
Ficke, Sylvia A. (9)
Fiedler, Michael J. (20)
Field, Frank L. (18)
Fielding, William M. (16)
**Fiering, Abraham M. (16)**
**Fietti, Vincent G. (2)**
**Fifer, William T. (9)**
Figurelli, Francis A. (9)
Filkins, Cedric E. (4)
**Fine, Hyman P. (12)**
**Fine, Irvin J. (12)**
**Fine, Sydney G. (11)**
Fineberg, Jacob C. (9)
**Finegan, Paul J. (11)**
**Finger, Frederick A. (9)**
Fink, A. Elston (7)
Fink, Irving E. (7)
**Fink, Stanley J. (20)**
Finke, Charles H. (9)
Finke, George W. (2)
Finke, John H. D. (2)
Finkel, Joshua (7)
**Finkelstein, Abe S. (7)**
**Finkle, Lester J. (11)**
Finkler, Rita S. (7)
Finn, Frederick A. (9)
Finn, Henry R. W. (9)
**Finnerty, Urban R. (7)**
Fiorello, Joseph R. (11)
Fischbach, Adolph D. (3)
**Fischbein, Martin M. (7)**
**Fischer, David D. (7)**
Fischer, Edward J. (7)
Fischer, Louise (7)
Fischman, Harold H. (7)
Fish, Clyde M. (1)
**Fishbein, Elliot (16)**
Fisher, James A. (13)
Fisher, Percy C. (2)
**Fisher, Samuel (16)**
Fisher, Stelia C. (4)
Fishkoff, Alexander H. (12)
Fisler, Charles F. (8)
**Fitch, Thomas S. P. (20)**
Fithian, George W. (12)
**Fitzhugh, William F. (2)**
Fitzpatrick, Edward F. (7)
**Fitzpatrick, Leo J. (2)**
**Flanagan, John J. (7)**
Flax, Charles H. (7)
**Flax, Ira I. (7)**
**Flax, Jacob L. (7)**
Fleischmann, Viola G. (7)
Fleming, Charles L. (17)
Fleming, Joseph A. (7)
Flichtenfeld, Morris (9)
**Flicker, David J. (9)**
Fliegel, Hilda C. (9)
Fliegel, William M. (2)
Flint, Edgar T. (18)
Flitcroft, William (16)
Floody, Robert J. (7)
Flower, Morrie A. (7)
**Fluck, David A. (11)**
Fluck, Paul H. (10)
Flynn, Edward A. (7)
**Foley, James F. (7)**
Fooder, Horace M. (8)
**Forbes, John S., Jr. (14)**
Ford, Theodore R. (7)
**Forer, Robert (11)**
Forney, Norman N. (12)
Forney, Norman N., Jr. (12)
Forsyth, Kenneth C. (7)
Fort, J. Irving (7)
Fort, William B. (20)
**Forte, Daniel L. (7)**
Forte, F. Chester (2)
Forte, Frank S. (7)
**Fortuin, Floyd (16)**
**Fortunato, Samuel J. (7)**
Fost, William H. (7)
Foster, Frank L. (20)
Foster, Herbert W. (7)
Fowler, Royale H. (7)
Fox, William W. (1)
Frame, Dorothy L. (7)
**Franey, Donald G. (7)**
**Frank, Herman I. (9)**
Frank, Morris (9)
Frank, Myrtile (1)
**Frank, Nathan (9)**
**Frank, Perry (1)**
**Franklin, Frank A. (7)**
Franklin, I. Harold (9)
Franklin, Joseph E. (20)
Franklin, Lewis J. (20)
**Franzoni, Andrew E. (11)**
**Fratantuno, Michael J. (7)**
Fraulo, Louis (16)
**Frazee, William H., Jr. (15)**
Freedman, Harold H. (13)
Freedman, Jacob S. (16)
Freeland, Frank (2)
**Freeman, George C. (7)**
Freeman, Joseph (9)
**Freeman, Ray M. (20)**
Freeman, Richard D. (7)
Freinkel, Jacob (7)
**Freyberger, George A. (9)**
Freymann, Walter (9)
**Fridrich, Harry E. (4)**
Friedburg, George H. (20)
**Friedenberg, Sidney (4)**
**Friedenthal, Bernard (12)**
Friedland, Arnold J. (6)
Friedlander, Kurt F. (7)
**Friedman, Abraham I. (2)**
**Friedman, Harry (7)**
Friedman, Hyman (7)
Friedman, Max (11)
Friedman, Meyer H. (11)
**Friedman, Milton (7)**
Friedmann, Leonard L. (11)
**Friedrich, Adam H. (7)**
Frieman, Hyman (9)
Fritsch, Alfred (7)
Fritts, Lewis C. (18)
Fritz, John F., Jr. (10)
Froelich, Joseph C. (7)
Frohwein, Ida H. (20)
Fromkin, Charles (6)
Frost, Inglis F. (14)
**Fruchtbaum, Robert P. (7)**
Frutig, Harold C. (9)
Fuchs, Jacob N. (11)
Fuhrmann, Barclay S. (10)
Furman, Benjamin A. (7)
Furman, Sol T. (9)
Furst, Nathan J. (7)

## ASSOCIATE MEMBERS

Faulkner, Mortimer S. (7)
**Feliciano, Vincent (16)**
Folmer, Edward (11)
**Forrest, Henry (12)**
Fortay, Stephen O. (16)
**Franklin, Charles M. (11)**
Friedman, Edna C. (16)

# G

## ACTIVE MEMBERS

**Gadek, Stanley A. (12)**
**Gadek, William V. (12)**
**Gadomski, Casimir F. (20)**
Galgoczy, Julius (18)
**Galioto, Frank M. (7)**
Gallardo, Agustin (16)
Gallaway, George E. (20)
**Gallo, James S. (16)**
Galotta, Margaret L. (2)
Gamba, Joseph (7)
Gambacorta, Leopoldo (7)
Gambill, Perry J. (14)
Gamon, Robert S. (4)
Ganley, Arthur J. (7)
**Gannon, Joseph M. (20)**
Ganot, Frank I. (7)
Gantt, Margaret H. (14)
Garbarini, John G. (9)
Gardam, Joseph W. (7)
Gardner, Kenneth E. (7)
**Garfinkel, Abraham (10)**
Garnett, Robert (16)
**Garrison, George H. H. (4)**
Garrison, W. Sherman (6)
Garwood, Norman W. (11)
**Gatti, Joseph D. (2)**
Gauch, William (7)
**Gaumer, George W. (15)**
Gauzza, Valentine P. (12)
Gaylor, Earl L., Jr. (7)
Geannette, Ernest D. (7)
Geary, Daniel J. (14)
Geary, Paul (20)
Geary, Russell D. (3)
**Gebirtig, Theodore (14)**
Gehl, Sidney H. (7)
**Geiger, Harold C. (16)**
Geissler, Elmer E. (4)
**Gelb, Jerome (7)**
Gelber, Isaac (20)
Geller, Samuel (7)
**Gelman, Sidney (16)**
**Gencher, Benjamin (7)**
Gennell, Ernest (7)
Gentile, Ernest R. (18)
George, Melbourne E. W. (7)
Gerard, Arpad G. (12)
Gerard, Patrick D. (7)
Gerendasy, Julius (20)
Gerhardt, Paul E. (7)
**Germain, Raymond J. (10)**
**German, George B. (4)**
**Gerne, Timothy A. (9)**
**Gerner, Harry E. (9)**
Gershenfeld, David B. (7)
**Gershman, Joseph G. (2)**
**Gessner, Gerard R. (12)**
Gesswein, Carl A. (13)
Ghee, Euclid P. (9)
Giambra, Sante M. (16)
Giardina, John S. (7)
**Giardina, Vincent J. (7)**
Gibb, Alice S. (20)
**Gibbins, A. Leslie (7)**
Gibson, Augustus (7)
Gibson, Charles F. (3)
Giffoniello, Arthur A. (7)
Gifford, William R. (7)
**Giglio, Alphonsus S. V. (20)**
Gilady, Raphael (2)
Gilbert, Harold F. (7)
**Gilbert, Philip D. (4)**
Gilbert, Samuel M. (7)
**Gilbertson, Robert L. (14)**
**Gilligan, Walter W. (7)**
**Gillis, Alfred G. (8)**
Gilman, Charles M. B. (7)
**Gilmour, John R. (7)**
**Gilpin, Fletcher (20)**
**Gindhart, John H. (11)**
Ginsberg, George (9)
**Ginsberg, Leon (7)**
Ginsburg, Samuel (16)
Giordano, William C. (2)
**Girardo, Anthony J. (4)**
**Gittelman, Morton (20)**
Gittelsohn, Isador (2)
**Gitterman, David A. (2)**
Giuffra, Frank (7)
Giuliana, Robert A. (7)
**Gladstone, Albert L. (2)**
Glaser, Emanuel (20)
Glasgow, Thomas M. (16)
Glass, Benjamin E. (20)
Glass, George A. (18)
**Glass, Harry L. (20)**
Glass, Oscar (7)
**Glass, William H. (7)**
**Glasser, Benjamin F. (12)**
**Glassner, Frank (20)**
Glasston, Hyman M. (20)
Glazebrook, Francis H. (14)
Glazer, Edward (13)
**Glazier, Jesse T. (7)**
**Gleason, Thomas P. (9)**
Gleeson, William J. (9)
Glover, Lawrence L. (4)
Gluckman, I. Edward (7)
Gluckman, Saul K. (7)
Gnassi, Angelo M. (9)
Gobel, Stanley J. (12)
Gochman, Harry M. (16)
**Godfrey, Alan O. (7)**
**Goeller, Jacob D. (7)**
**Goff, Frank J. (13)**
Goffman, Emanuel (7)
Goldberg, Benjamin M. (11)
Goldberg, David (2)
Goldberg, Harold H. (7)
Goldberg, Harry C. (12)
Goldberg, Isidore (12)
Goldberg, Louis E. (7)
Goldberg, Samuel A. (7)
**Golden, Clement H. (7)**
**Golden, William M. (20)**
Goldenberg, Raphael R. (16)
**Goldfarb, Abraham (2)**
Goldfield, Harold H. (20)
Golding, Harry N. (16)
Goldmacher, Herman B. (20)
**Goldman, Jerome (7)**
Goldman, Leo L. (11)
Goldman, Lester M. (7)
Goldman, Samuel (4)
Goldman, Solomon (12)
Goldmann, Joseph (7)
Goldowsky, Ira (9)
**Goldsmith, Alfred S. (9)**
Goldstein, Abraham (15)
Goldstein, Edward W. (16)
**Goldstein, Henry Z. (7)**
Goldstein, Herman H. (20)
Goldstein, Hyman I. (4)
**Goldstein, Joseph D. (9)**
**Goldstein, Samuel (1)**
Goldstein, Samuel M. (7)
Goldstein, William H. (7)
Goldstone, Karl H. (9)
**Gonczy, Edward J. (20)**
Goodman, Kenneth (7)
Goodrich, Stewart L. (9)
Gordon, A. Julius (7)
**Gordon, Abel (16)**
Gordon, Benjamin L. (1)
Gordon, Charles D. (14)
Gordon, Frank S. (21)
Gordon, Isaac L. (9)
Gordon, J. Berkeley (13)
Gordon, Maurice B. (1)
Gordon, Milton H. (4)
**Gordon, Samuel (16)**
Gordon, Sarah (2)
**Gorenberg, Harold (9)**
Gormley, Cyrus M. (16)
Gorog, Nicholas M. (12)
Gorson, Samuel F. (1)
Gorten, Manfred L. (7)
Gosper, Ralph W. (4)
**Gottlieb, Morris (1)**
Gould, John H. (16)
**Gould, Werner (2)**
Graddick, Lester W. (14)
**Graeter, F. Albert (16)**
Graham, Archibald F. (16)
**Graham, Ernest E. (11)**
Graham, Theodore K. (16)
Gramsch, A. Louis (2)
Granelli, Humbert A. (9)
**Grant, Francis (7)**
Grant, Raymond J. (14)
**Grant, William E. (20)**
**Grant, William F. (7)**
**Grasso, Anthony P. (7)**
**Graves, Charles C., Jr. (13)**
Gray, Charles M. (6)
Gray, John W. (7)
Gray, W. Burritt (18)
Green, David W. (17)
Green, Thomas J. (15)
**Greenberg, George A. (18)**
Greenberg, Jacob L. (7)
Greenberg, Max (20)
Greenberg, Philip (9)
Greenberg, Samuel (7)
**Greenberg, Solomon (9)**
Greene, Albert D. (9)
**Greene, Edwin C. (6)**
**Greene, Harry (9)**
Greenfield, Arthur W. (2)
Greenfield, Bernard H. (7)
Greenfield, Herbert (7)
Greenfield, Leonard S. (7)
Greenfield, William J. (2)
Greengrass, Jacob J. (16)
Greenwald, Theodore L. (7)
Greenwood, Samuel B. (7)
Greenwood, William R. (12)
**Greer, Melvin A. (7)**
Gregorius, Ralph F. (7)
Gregory, Marie F. (14)
Gregory, Mildred G. (7)
Greifinger, Marcus H. (7)
**Greifinger, William (7)**

**Grenhart, George W. (4)**
Gricco, Anthony L. (6)
**Grieco, Emil H. (9)**
Grier, Robert M. (1)
Griesemer, Z. Lawrence (20)
Grieve, James (12)
**Griffey, William C. (4)**
Griffin, Guy B. (7)
Griffith, Roy (7)
**Grimes, Robert R. (2)**
Griscom, I. Norwood (14)
Griscom, Lee E. (4)
**Griswold, Merton L., Jr. (20)**
**Groeschel, August H. (19)**
Groff, Parker A. (2)
**Gross, Irving (7)**
Gross, Max (1)
**Grossblatt, Philip (7)**
Grossman, Morris (9)
**Grossman, Rubin (9)**
**Gruber, William L. (7)**
**Grubin, Harold (7)**
Grubowski, Joseph N. (9)
**Grueninger, Edward F. (2)**
**Gruhler, Jean A. (1)**
Grunt, Louis (7)
**Guarraia, Joseph (16)**
**Guertin, Diomede (18)**
Guglielmelli, Angelo D. (11)
Guidi, Guido M. (20)
**Guidotti, Frank P. (11)**
Guion, Edward (1)
**Gulick, James B. (7)**
**Gullord, Edward G. (7)**
Gurland, Benjamin B. (9)
Gurley, Katharine A. (9)
**Gurnee, Quinby D. (16)**
**Gurshman, Sol. (12)**
Guthrie, Wilson G. (7)
**Gutmann, Erwin K. (9)**
Gutowski, Joseph M. (12)
Gutowski, Walter T. (7)

ASSOCIATE MEMBERS

Gahan, Emanuel (11)
Gellman, William B. (16)
Gershenson, Wilbur M. (16)
**Glynn, S. Robert (7)**
Goldberg, Bernard R. (7)
**Goldman, Sol B. (16)**
Granger, James R. (11)
**Gribbin, James A. (11)**
Grossman, Walter (12)

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# H

ACTIVE MEMBERS

Hadley, C. Frazer (4)
Hadley, C. Frazer, Jr. (4)
Hadley, Elinor E. (7)
Hafetz, M. Morris (11)
**Hagen, Walter H. (7)**
Haggerty, D. Leo (11)
**Hagman, Frank E. (7)**
Hagovsky, Albert J. (2)
Hahn, Katharine B. (7)
Hahn, William H. (7)
Haight, Harry W. (12)
Haines, Edgar J. (3)
**Haines, Emerson S. (13)**
Haines, F. B. Lane (5)
Haines, Mabel C. S. (4)
Haines, Willits P. (5)
**Halbstein, Bernard M. (13)**
**Haldeman, Robert E. (3)**
Hale, Matthew J. (3)
**Haley, Paul W. (7)**
Hall, Perry O. (9)
Hall, Wayne W. (16)
**Hall, Winthrop H. (20)**
Hallett, Frederick S. (2)
Halligan, Earl J. (9)
Halligan, Harold J. (9)
Hallinger, Earl S. (4)
Hallock, Wilton J. (20)
**Halnan, John J., Jr. (16)**
Halperin, David (9)
Halpern, Herman (2)
**Halpern, Jesse O. (2)**
**Halpern, Melvin M. (7)**
**Halpern, Samuel (1)**
Halpern, Sophia L. (9)
**Halpern, William (7)**
**Halprin, Harry (7)**
Halsey, Levi W. (7)
Hambright, Arthur M. (16)
Hamilton, Lloyd A. (10)
Hamilton, Robert G. (7)
**Hamley, John J. (20)**
**Hammell, Frank M. (11)**
Hampton, George R. (14)
Hanan, James T. (7)
**Hancock, Michael Q. (13)**
**Handler, Harry (9)**
Haney, John J. (11)
Hansen, Harold T. (7)
Hansen, Harry (20)
Hanson, Alfred S. (4)
Hanson, Carl G. (20)
Hantman, Harold (7)
Harden, Albert S. (7)
**Harden, Albert S., Jr. (7)**
Hardy, Grace C. (2)
**Hardy, John W. (13)**
Harman, Byron M. (7)
Harman, James R. (11)
Harman, William J. (11)
Harreys, Charles W. (16)
**Harrington, J. Henry (14)**
**Harris, Morris (7)**
Harris, William G. (8)
**Harris, William O. (1)**
Harrop, George A. (11)
Harryman, William K. (2)
Harter, Louis F. (9)
Hartman, Luther M. (3)
**Hartman, Winfield L., Jr. (7)**
Hartwell, H. Ameroy (9)
Harvey, John W. (9)
**Harvey, Robert K. (7)**
Harvey, Thomas W., Jr. (7)
**Harz, William V. (9)**
Haschec, Walter (7)
Hasking, Arthur P. (9)
**Hasney, Frederick A. (7)**
Hatch, Harold S. (14)
**Hatcher, George A. (7)**
Hatem, Elias J. (16)
Hauber, Eugene A. (12)
Hauck, Lydia R. B. (7)
Hauck, William H. (7)
**Hauptman, Harry (9)**
Haury, Victor G. (4)
Hausman, Samuel W. (13)
Haven, Samuel C. (14)
**Hawes, Vernon L. (2)**
**Hawke, Edward K. (19)**
Hawkes, E. Zeh (7)
**Hawkes, Stuart Z. (7)**
Hayden, Walter G. (15)
**Hayes, Gerald W. (7)**
**Hayman, Irving R. (16)**
Hays, Roy G. (4)
Haywood, Henry (12)
**Heatley, William (13)**
**Heaton, Stuart C. (18)**
**Hebble, Howard M. (3)**
Hegeman, Runkle F. (18)
**Heineken, Theodore S. (7)**
Hekimian, Jacob H. (9)
Helff, Joseph R. (2)
Heller, Abraham R. (7)
**Heller, George (2)**
Heller, Nathan B. (7)
**Heminway, Norman L. (18)**
**Hemphill, Everett H. (4)**
Hendlich, Milton G. (7)
Henle, Carye-Belle (7)
Hennig, Paul F. (7)
**Henriksen, J. Bruce (15)**
Henry, Frank C., Jr. (12)
Henry, George (10)
Henry, Norman (6)
**Hensle, Otto S. (2)**
Herbener, Eugene G. (15)
Hermann, John H. (7)
Hernandez, Manuel (9)
Herndon, Lewis S. (7)
Herold, Harvey T. (7)
Herradora, Juan R. (9)
Herrington, Lee R. (20)
Herrman, William G. (13)
**Hersh, David H. (7)**
**Hersohn, William W. (1)**
**Hess, George A. (11)**
Hess, L. Elmore (1)
**Hesseltine, Clair E. (12)**
Hessert, Edmund C. (4)
**Hewson, George F. (7)**
**Heyman, Arthur (7)**
Heymann, Ernest F. (13)
**Hicks, Alfred M. (7)**
Hiden, Joseph C. (11)
Higgins, Gerald L. (9)
Higgins, John T. (9)
Higgins, Thomas A. (9)
**Higl, Joseph E. (7)**
**Hiller, Stuart A. (14)**

Hilker, George F. (12)
**Hill, Dean F. (19)**
Hill, James O. (7)
Hill, Robert H. (7)
**Hillel, Joseph (9)**
Hilliard, William T. (17)
**Hillmann, Frederick C. (16)**
**Hillsman, R. Bryan (2)**
Hindle, F. Lawton (13)
Hinton, Samuel H. (12)
Hipple, Percy L. (20)
Hird, Emerson F. (18)
Hirsch, Arthur (5)
**Hirsch, John J. (2)**
Hirsch, Samuel (16)
**Hirsch, Solomon (9)**
Hirsch, Theodore (7)
**Hirschfield, Bernard A. (11)**
**Hitzemann, Louis A. (2)**
**Hnat, Frederick (20)**
Hobart, Richard T. (7)
Hochheimer, Arthur (18)
**Hodas, Sidney M. (13)**
Hofer, Clarence J. M. (12)
Hofer, William R. (4)
**Hoffman, Charles A. (20)**
**Hoffman, Charles W. (12)**
Hoffman, Florentine M. (12)
Hoffman, Harry S. (1)
**Hogan, James J. (15)**
Hogan, Marshall D. (14)
Holderith, Albert E. (7)
**Holland, Moses H. (9)**
Holland, Reuben J. (20)
Holler, Henry G. (7)
Hollingsworth, H. Hale (16)
Hollinshed, Beulah S. (4)
Hollinshed, Ralph K. (8)
**Hollywood, James L. (9)**
**Holman, Francis W. (13)**
Holmes, George J. (7)
Holmes, Grace A. (20)
Holmes, H. David (1)
Holmes, Thomas J. E. (16)
**Holoman, M. Browne (1)**
**Holster, Stephen G. (16)**
Holt, Edward Z. (1)
Holt, Herman H. (16)
Holters, Otto R. (13)
**Holtz, Harry M. (7)**
Holtzman, Michael (20)
Hooton, Thomas C. (7)
**Hopping, Richard A. (7)**
**Horhovitz, George I. (11)**
**Horland, Aaron H. (7)**
**Horn, Harry (7)**
Horn, Max (7)
Hornberger, J. Howard (3)
Horner-Rodger, Clara L. (4)
Hornstine, Harry H. (5)
Horoschak, Anne (20)
**Horowitz, Herman J. (2)**
Horowitz, Leo (9)
Horre, George W. H. (20)
Hosp, Paul H. (7)
Howard, J. Edgar (4)
**Howard, James W. (7)**
Howell, E. Gaylord (12)
**Howell, Thomas W. (7)**
**Howeth, John L. (9)**
**Howley, Barth, Jr. (12)**
Hubach, Maximilian F., Jr. (7)
Hubbard, Harry V. (20)
Hubbard, Robert Y. (7)
Huber, William H. (7)
Huberman, John (7)
Hubert, Antonio O. (14)
**Hudson, Howard S. (1)**
Hughes, Frank J. (4)
Hughes, Frank R. (5)
Hughes, Frederic J. (20)
Hughes, J. Vernon (16)
**Hughes, Joseph F. (8)**
Hughes, Lee W. (7)
**Hughes, Samuel B. (5)**
Hughes, Thomas E. (4)
**Hulett, Albert G. (7)**
**Hull, Donald B. (2)**
**Humbert, Joseph C., Jr. (21)**
Hummel, Ernest G. (4)
**Hummel, Lee C. (17)**
**Hummel, Merwin L. (4)**
Humphrey, Hubert G. (20)
Humphries, Robert E. (7)
Hunt, Melvin M. (12)
Hunt, Thomas F. (20)
Hunter, Edward R. (3)
**Hunter, Floyd D. (11)**
Hurff, J. Wallace (7)
Husserl, Siegfried (7)
**Husted, Gerald W. (4)**
Husted, Samuel H. (18)
Hutchinson, A. Dunbar (11)
Hutchinson, George F. (11)
**Hutner, Cyril I. (12)**
Hutton, Frederick T. (20)
Hyer, Godfrey S. (18)
Hyman, Charles (1)
Hymowitz, Ben (7)

ASSOCIATE MEMBERS

Haller, Olga (7)
Hillman, Ernest C., Jr. (7)
Hofbauer, Ernest (11)

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# I

ACTIVE MEMBERS

**Ianacone, John A. (16)**
Iatesta, Matthew (7)
Ill, Edmund W. (7)
**Ill, Herbert M. (7)**
**Imbleau, Joseph E. (20)**
**Imhoff, John G. (9)**
**Imhoff, Robert E. (3)**
**Infield, Gerald L. (1)**
Inge, Hutchins F. (7)
Inge, Theodore R. (7)
Ingling, Harry W. (13)
Introcaso, Dominick A. (9)
**Iraggi, James V. (16)**
Ironside, Paul A. (4)
Irvin, John S. (1)
**Irving, Henry C. (9)**
Irwin, James R. (7)
Irwin, John H. (2)
Isaac, Benoit C. (7)
Ishkhanian, Nouri I. (9)
Israeloff, Howard H. (7)
Ivins, William C. (11)
**Ivory, Harry S. (15)**
Izenberg, David (16)

ASSOCIATE MEMBER

Idelcowitz, Marie (12)

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# J

ACTIVE MEMBERS

**Jablonski, John J. (12)**
Jack, H. Wesley (4)
Jacks, Oscar (9)
Jackson, Albert F. (7)
Jackson, Charles H. (4)
Jackson, Elmer C. (21)
Jackson, George H. (7)
**Jackson, Kenneth K. (7)**
Jacobitti, Edmund E. (2)
**Jacobs, Alan L. (20)**
**Jacobs, William (7)**
Jacobson, J. Joseph (1)
**Jacobson, Murray B. (12)**
**Jaeckle, Charles E. (7)**
**Jaffe, Benjamin (9)**

Jaffe, Herman M. (9)
Jaffe, Hyman (16)
Jaffin, Abraham E. (9)
Jahn, Albert G. (16)
James, Bart M. (7)
**James, J. Thomas (11)**
Jamison, William F. (13)
Jani, Frank F. (16)
Janifer, Clarence S. (7)
Janoff, Henry (11)
Jaques, J. Eugenia (9)
Jarmulowsky, Harry (16)
Jaslow, Seymour P. (2)
Jaso, James V. (7)
Jaspan, Samuel C. (11)
Jedel, Meyer (7)
**Jehl, Joseph R. (16)**
Jenkins, Alvah R. (2)
Jenkins, Arthur M. (10)
Jenkins, R. Jewett (7)
**Jennings, Robert E. (7)**
Jentz, John H. (9)
Jessurun, Samuel H. (7)
Jirouch, Edwin A. (17)
Joelson, Dora (16)
Joelson, Morris S. (16)
**Joffe, Philip M. (16)**
**Joffe, Sidney H. (16)**
Johnsen, Sigurd W. (16)
Johnson, Archie W. (9)
Johnson, George F. (19)
**Johnson, G. Leonard (2)**
Johnson, Harold F. (20)
**Johnson, Herbert F. (4)**
Johnson, John F. (11)
Johnson, Robert A. (7)
Johnson, V. Earl (1)
Johnston, Julian F. (14)
**Johnston, Rufus O. (2)**
**Johnston, Sidney F. (2)**
Jonas, August (17)
Jones, Clement M. (9)
Jones, Granville L. (13)
**Jones, Herbert E. (20)**
Jones, J. Morgan (9)
Jones, John C. (4)
Jones, Rhys (7)
Jonitz, Robert (7)
**Jordan, Joseph C. (13)**
Joseph, Benjamin M. (9)
Joseph, Morris (16)
**Joy, Ernest H. (15)**
**Judge, John F. (7)**
**Judson, G. Vernon, Jr. (4)**
**Judy, Kenneth H. (9)**
Jukofsky, Isidore D. (2)
Just, Francis (7)
Justin, Arthur W. (9)

ASSOCIATE MEMBERS

Jarvis, Daniel G. (7)
Jones, Helen E. (13)

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# K

ACTIVE MEMBERS

Kachdorian, Vartan (11)
Kaderabek, Erwin J. (7)
Kahn, Leo (1)
Kahrs, Grace M. (7)
Kaighn, Charles B. (1)
Kain, Thomas M. (4)
**Kainer, Herbert (9)**
**Kakascik, Emil J. (2)**
Kalb, S. William (7)
**Kallen, Arnold M. (7)**
Kalter, George E. (7)
Kanengiser, Clifford H. (9)
**Kaney, Emil M. (7)**
**Kaplan, Henry L. (7)**
Kaplan, Herman B. (9)
Kaplan, S. Bernard (7)
**Kaplan, Samuel D. (20)**
Kapp, Carl G. (20)
Karnasiewicz, Francis (20)
**Karshmer, Ernest E. (20)**
**Karshmer, Nathan (12)**
Kassow, Philip B. (21)
Kastler, Franz (2)
Katz, Harry (16)
Katz, Herbert I. (16)
Katz, Jacob D. (9)
**Katz, Sidney (9)**
Katz, Theodore (20)
Katzin, Eugene M. (7)
Kauffmann, Louis J. (6)
Kaufman, Jerome G. (7)
Kaufman, Michael J. (7)
Kavanaugh, Daniel E. (7)
Kay, Albert E. (12)
Kay, Clarence R. (18)
**Kazmann, Harold A. (13)**
**Kearney, Edward P. J. (7)**
Kearney, John V. (9)
Keating, Charles A. (16)
**Keating, Joseph M. (16)**
Keegan, Thomas D. (9)
Keeney, Cadwell B. (20)
**Keeney, James C. (9)**
Keil, Sigmund S. (20)
Keim, William F., Jr. (7)
Keir, Floyd E. (2)
Keith, Theodore R. (7)
Kelemen, Nicholas M. (7)
**Keller, Michael L. (16)**
Kelly, Bernard S. (9)
**Kelly, Harry R. J. (9)**
**Kelly, Leo J. (12)**
Kemeny, George (20)
Kemeny, Imre (12)
Kempe, George (7)
**Kennedy, A. Andrew (16)**
Kennedy, Eugene T. (16)
**Kennedy, John W. (9)**
Kennedy, Paul A. (2)
**Kennedy, William M. (7)**
Kenney, John A. (7)
Keppler, Charles, Jr. (16)
**Kerdasha, Richard F. (4)**
Kern, E. Clarence (7)
Kerns, Francis J. (7)
**Kesseli, John S. (7)**
Kessler, Edward I. (14)
Kessler, Henry B. (7)
**Kessler, Henry H. (7)**
**Keyser, David (4)**
**Kibbe, Milton H. (20)**
Kidd, Ruth W. (20)
Kicly, Eugene M. (9)
**Kiessling, Charles E. (7)**
Kiley, John E. (7)
Kilts, Winfield S. (2)
Kim, Gay B. (16)
Kimler, William D. (4)
**Kimmel, Charles (7)**
**Kimmel, M. Leonard (9)**
Kimmel, Seymour S. (21)
Kinczel, John A. (11)
King, Alden P. (14)
King, Chester A. (2)
Kingslow, George L. (2)
Kinley, John W. (7)
Kinney, Albert G. (4)
Kinney, Burton O. (16)
Kirkby, Cyril S. (7)
Kirkman, Leroy G. (7)
Kirkwood, Allan S. (7)
Kirschner, Martin I. (19)
**Kissinger, Donald J. (2)**
Klarich, Philip (4)
Kleiber, Estelle E. (12)
Klein, Alexander (12)
**Klein, Andrew J. V. (7)**
**Klein, Edward C., Jr. (7)**
Klein, Edward F. (12)
Klein, Julius (9)
Klein, Milton (14)
Klein, William (12)
Kleinberger, Harry H. (7)
Kleiner, Samuel (16)
**Kleinman, Maurice (7)**
Kleinmann, Eberhart H. (16)
Klempner, Paul (11)
Klenk, Joseph P. (7)
Kler, Joseph H. (12)
**Kline, George L. (7)**
**Kline, Herman (1)**
Kline, Joseph J. (11)
Kline, Oram R. (4)
**Klompus, Irving (18)**
Klosk, Emanuel (7)
**Klosterman, Julius A. (2)**
Klughaupt, Dorothy K. (16)
Knapp, Richard E. (2)
Knapp, Victor (13)
Knauer, George (20)
Knight, Augustus S. (18)
**Knight, William T. (2)**
Knowles, Frederick E. (14)
**Knowles, George M. (2)**
Knowles, James S. (6)
Knox, Charles A. (2)

Knox, Harriet L. (2)
Knox, Howard A. (10)
**Kobes, John J. (7)**
**Koeck, George P. (7)**
Koelsch, Frederick J. (12)
Koenig, Bertram (16)
**Koerber, George (16)**
**Kohn, Joseph J. (11)**
**Kohn, Leo (7)**
**Kohn, Ralph B. (11)**
**Kohut, George J. (12)**
Kolb, John M. (9)
Kolodin, Abraham (7)
**Kondor, Joseph S. (11)**
Konzelman, Henry J. (20)
Konzelmann, Frank W. (1)
Kooperman, Barnett (9)
**Kooperstein, Samuel I. (9)**
Koplin, Nathaniel H. (11)
Koppel, Joseph A. (9)
Kornfeld, Werner (7)
**Kosminsky, Louis (2)**
Kossmann, Walter J. (14)
Kosterlitz, Henry H. (7)
Kovaleski, Walter A. (16)
Kovin, Abraham (16)
**Kraczyk, Michael J. (4)**
**Kraemer, Manfred (7)**
Kraemer, Samuel H. (9)
**Krafchik, Louis L. (12)**
**Kraissl, Cornelius J. (2)**
Kraker, David A. (7)
Kralik, Joseph J. (7)
**Kramer, Bernard M. (12)**
Kramer, Douglas W. (20)
Kramer, Samuel E. (12)
**Krans, DeHart (20)**
Krans, Edward S. (20)
**Kratka, William H. (6)**
Krauss, Fletcher I. (14)
Krausz, Emery (21)
**Kraut, Arthur M. (9)**
Krechmer, Abraham (1)
Kresch, Philip (9)
**Kreutz, Paul J. (20)**
**Krichbaum, Carroll E. (7)**
**Krieger, George (16)**
Krone, William F. (7)
**Kruger, Alfred L. (9)**
Kruger, William (7)
Kuchlewski, Edward J. (20)
**Kuder, Joseph M. (3)**
Kuhlmann, Alvin E. (9)
**Kuite, George B. (14)**
Kummel, Max (7)
Kump, Albert B. (6)
**Kun, Bertram (9)**
**Kunz, Harold G. (7)**
**Kuperman, Henry L. (7)**
**Kushner, Alexander (20)**
Kustrup, John F. (11)
**Kutner, Charles (4)**
**Kwint, Joseph A. (20)**
Kyle, Ernest I. (20)

ASSOCIATE MEMBERS

**Kaletkowski, Marion F. (16)**
**Kauder, Warren G. (7)**
Kearny, Paul A. (7)
**Korman, Arnold (16)**

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# L

ACTIVE MEMBERS

**Laauwe, Harold W. (16)**
**La Barba, Peter J. (2)**
Labow, Joseph J. (20)
Ladas, George (20)
Lafferty, Elton B. (7)
**Lakiszak, Roman T. (9)**
Lamberto, Vito A. (2)
**Lance, Elton W. (20)**
Landaw, Louis (16)
Landes, Edwin W. (19)
**Landesman, William (7)**
**Landis, Harry P., Jr. (3)**
**Landshof, Charles A. (9)**
Lane, Austin W. (7)
Lane, Edgar W. (10)
**Lane, Thomas F. (9)**
**Lang, Joseph (12)**
Lang, Louis (20)
Lange, Louis C. (9)
Langston, Junius T. (20)
**Lapin, Louis P. (11)**
**Lapin, Samuel B. (11)**
Largay, Arthur C. (9)
Larkey, Charles J. (9)
**Larkey, Irving G. (7)**
Larossa, Ernest A. (4)
Larrabee, Callie H. (20)
Larson, Henry M. (14)
**Larsson, Evert A. (11)**
Lathrop, Frederic W. (20)
Lathrope, George H. (14)
Latona, Joseph A. (2)
**Laudig, Guy H. (14)**
**Laurie, Andrew L. (20)**
Lavine, Barney D. (11)
**Lavine, Samuel C. (12)**
Lavine, Sidney B. (11)
**Lawless, Edward T. (7)**
Lawrence, Arthur C. (16)
Lawrence, Elias D. (16)
Lawrence, William H. (20)
Lawsing, G. Conde (9)
Lawther, Boyd M. (1)
**Lawton, A. Anderson (18)**
**Lazow, S. Manlius (12)**
**Leach, John E. (16)**
**Leaman, Granville M. (7)**
Lease, Henry J. (9)
Le Bel, Louis J. B. (7)
Leber, Otto H. (7)
**Lee, Benjamin F. (4)**
Lee, Frederick P. (16)
Lee, John J. (7)
Lee, Robert E. (7)
Lee, Thomas B. (4)
**LeFavor, Dean H. (3)**
**Leff, William A. (7)**
Lefkovics, Sidney C. (7)
**Legato, Samuel F. (2)**
Leggett, Lindley H., Jr., (20)
Leggett, Thomas H., Jr. (20)
Lehmacher, Frank (15)
**Lehman, David J., Jr. (7)**
Leibovitz, Altan C. (16)
Leining, Albert (9)
Leir, J. Krevin (9)
**Lemay, Albert T. (16)**
**Lemkin, Samuel (7)**
**Lemmerz, Willard H. (2)**
**Lemmon, Junius M. (21)**
Leonard, George F. (12)
Leonard, Isaac E. (1)
**Leonard, Isaac E., Jr. (1)**
Leonard, Lothair L. (13)
**Lepis, A. Albert (9)**
**Lepree, Joseph A. (20)**
Lerman, Irving (20)
**Lerman, Samuel (20)**
Leshin, Harry (11)
Lesko, Stephen W. (2)
Lettiere, Anthony J. (11)
**Levendusky, Daniel E. (16)**
**Levin, Jack (13)**
Levin, Joseph (7)
Levin, Louis (11)
**Levin, Murray (7)**
**Levine, Edward P. (7)**
**Levine, G. Irving (9)**
LeVine, Israel (16)
Levine, Philip (7)
Levine, Sidney C. (16)
Levinsohn, Sandor A. (16)
**Levinson, David M. (7)**
Levinson, Louis J. (7)
**Levinson, Reuben (12)**
**Levinson, Robert M. (7)**
**Levison, William (7)**
Levitas, George M. (2)
**Levitas, Irving M. (2)**
Levitt, Jesse N. (7)
Levy, Abram (18)
Levy, Anna L. (7)
Levy, David (16)
Levy, Herman (16)
Levy, Irvin (11)
Levy, Jack D. (2)
Levy, Julius (7)
**Lewandowski, Edmund E. (7)**
Lewis, Albert (20)
Lewis, Alice B. (2)
Lewis, Collins E. (12)
Lewis, G. Rae (7)
Lewis, Jacob (13)
**Lewis, Leon (7)**
Lewis, Thomas K. (4)
**Liana, Stephen M. (16)**
**Liccese, Emanuel (7)**
**Licks, Frederick C. (7)**
**Liddell, Raymond N. (18)**
**Liddy, Frank J. (2)**
**Lieb, Saul (7)**
Lieberman, David P. (20)
**Lieberman, Milton L. (20)**

Lief, Lawrence H. (12)
Liegner, Ben (7)
Light, Arthur B. (11)
**Lilien, Bernard B. (7)**
**Lilien, Milton (7)**
Lilien, Milton M. (20)
Lima, John G. (16)
Linares, A. Carfi (16)
Lincoln, Jennings S. (7)
Linden, Mortimer H. (9)
Lindroth, Lawrence V. (9)
Linke, James J. P. (20)
Lintz, Sidney Z. (8)
Lipkin, Isadore (17)
Lippincott, Lansing Y. (20)
Lipshutz, Benjamin (9)
**Lipshutz, Charles (9)**
**Lipstein, William (7)**
**Lipton, Louis (16)**
Lisanti, Gaetano (9)
Little, Alonzo W. (9)
Little, William R. (11)
Littwin, Charles (2)
Liva, Arcangelo (2)
**Liva, G. Albin (2)**
Liva, Paul F. (2)
Livengood, Baxter A. (8)
Livengood, Horace R. (20)
Livingston, Bernard (7)
Livingston, Paul (7)
**Lloyd, Samuel J. (11)**
Llull, Gabriel J. (20)
**Lobban, Robert B. (9)**
Lobsenz, Nathan P. (16)
Locke, Henrik W. (4)
**Loder, Horace B. (6)**
Loder, Joseph S. (7)
**Loeb, William A. (18)**
**Loeser, Lewis H. (7)**
**Loksa, Harold T. (14)**
**Loman, Samuel G. (2)**
Lomauro, James R. (16)
**Lombardi, Frank L. (2)**
**Lomhoff, Irving I. (7)**
London, Jules R. (16)
London, William (12)
Londrigan, Joseph F. (9)
**Londrigan, Joseph F., II (9)**
**Long, John F. (7)**
Long, Miles T. (9)
Long, Pauline A. (12)
Longnecker, John E., Jr. (19)
**Longo, James J. (7)**
Longsdorf, Harold E. (3)
Longshore, Walter E., Jr. (7)
Loori, William A. (9)
Loper, John C. (6)
**Lord, C. Donald (2)**
Lore, Harry E. (6)
**Lorenzo, Michael J. (13)**
Losada, Camella A. (20)
Love, Elizabeth F. (3)
Lovell, John F. (7)
Lovett, Joseph C. (4)
Low, Donald B. (16)
Lowell, Milton E. (20)
Lowenstein, Aaron (7)
**Lowenstein, Ernest C. (20)**
Lowenstein, Harry A. (7)
Lowits, Otto (7)
Lowrey, James H. (7)
Lowy, Otto (7)
Luban, Benjamin (7)
Lucas, W. Fred (3)
Lucent, S. Bell (16)
**Lucey, James J. (12)**
Luczynski, Edward W. (9)
Ludlum, Walter D. (20)
Lufburrow, Charles B. (20)
**Luippold, Eugene J., Jr. (14)**
Luksteid, Casimir J. (16)
Lummis, Clarence P. (17)
Lundblad, Walter E. (7)
Luongo, Federico (7)
Lupin, Edward E. (9)
Lupo, Domenico (7)
**Luria, Sanford A. (2)**
Lurie, Solomon I. (7)
**Lurie, Wolf (7)**
Lushear, Frank H. (19)
Lussier, Georges H. (13)
Lutz, William M. (7)
**Lyerly, James M. (20)**
Lynch, Albert E. O. (7)
Lynch, Donald C. (11)
**Lynch, Edward T. (20)**
**Lynch, Maurice M. (2)**
**Lynch, Michael F. (20)**
Lynch, Roland J. (9)
**Lynn, Hugh B. (7)**
**Lynn, Irving I. (9)**
Lyon, Archibald (7)
Lyon, Charles H. (21)
Lyon, Earl C. (6)
Lyons, James V. (7)
Lyons, Romola L. K. (2)

ASSOCIATE MEMBERS

**Lang, Richard E. (16)**
Lapin, Mathew R. (11)
Lind, Zoltan H. (12)
Linz, Curt (7)
London, Leslie (16)
Lowe, Louise (2)

# M

ACTIVE MEMBERS

Maas, Max A. (7)
Mabey, J. Corwin (7)
MacAlister, William W. (16)
MacAlpine, Kenneth B. (4)
**Macaluso, Dominic C. (7)**
**MacArt, James H. (7)**
MacArthur, Clymont (7)
Macaulay, Francis A. (2)
**MacBrayer, Reuben A. (20)**
Macchia, Benjamin J. (9)
MacDermid, Lynden E. (11)
MacDonald, Edward O. (20)
MacDonald, John J. (9)
Macdonald, Wentworth S. (7)
Mace, Margaret (5)
MacGregor, Allan W. (16)
MacGuffie, Robert N. (16)
MacKellar, James M. (2)
MacKenzie, Robert A. (13)
Mackes, Claude B. (17)
**Mackin, John J. (9)**
Mackler, Harry S. (20)
Mackler, Meyer E. (16)
**MacLaren, Philip J. (2)**
Maclay, Joseph A. (16)
**MacMillan, C. Wright (7)**
Macpherson, Elwood H. (7)
Madaras, John S. (9)
Maddren, Russell F. (2)
**Mader, A. Ivan, Jr. (2)**
Madison, L. Keith (9)
Maffongelli, Joseph A. (16)
**Magee, Edward S. (4)**
Magee, Harold S. (11)
Magee, Russell S. (4)
Maggio, George A. (7)
Maggio, Nicholas A. (7)
**Maggio, Ross J. (20)**
**Magill, Marcus (1)**
**Magnes, Max (16)**
**Magolda, Anthony F. (6)**
**Magovern, Thomas F. (7)**
Magson, Albert E. (11)
Mahaffey, J. Lynn (4)
Maher, John E. (13)
Mahoney, Thomas H. (2)
Mahood, Herbert L. (7)
**Maisel, Irving (7)**
Majeski, Henry J. (11)
**Major, Morton M. (1)**
Makin, John B. (13)
Malatesta, Charles S. (20)
Maldeis, Albertos M. K. (4)
Malinowski, John (9)
Mallison, Herbert (20)
Mamlet, Alfred M. (7)
Manahan, Daniel V. (13)
**Mancene, Edward M. (2)**
Mancusi-Ungaro, Elviro (7)
Mancusi-Ungaro, Lodovico (7)
Manfro, Gerard J. (7)
Mangelsdorff, Arthur F. (18)
Mangogna, Philip (12)
Manly, Thomas E. (16)
**Mann, Benjamin (12)**
Mann, Jacob J. (12)
Manser, Ernest E. (4)
Manzione, Frank A. (16)
Maps, Howard L. (16)
Marcarian, Henry G. (4)
Marchione, Nicholas E. (6
Marcus, Bernard (18)
**Marcus, Donald (7)**
Margaretten, Edward I. (12)
Margolis, Alfred (7)
**Margulies, Charles (7)**
Marin, Robert B. (7)
Marini, Dominick (16)

Mark, Harold I. (2)
Mark, Harry B. (3)
Mark, Joseph S. (12)
**Markel, Albert G. (16)**
Markley, Luther A. (2)
Markowitz, Benjamin B. (9)
Markowitz, Irwin B. (9)
Markowitz, Louis (16)
Marks, Zelda I. (7)
**Marlett, Neumann C. (21)**
Marone, Carmine R. (20)
**Maroney, James H. (20)**
**Marquis, Dean W. (7)**
Marquis, W. James (7)
Marra, Rocco S. (7)
**Marrella, Louis F. (9)**
**Marrocco, William A. (16)**
**Marshall, Frank A. (9)**
Marshall, H. Donald (1)
**Martin, Leonard J. (13)**
**Martin, Theodore (16)**
Martin, William (4)
Martin, William P. (7)
Martland, Harrison S. (7)
**Marts, George H. (20)**
**Marvel, Peter H. (1)**
Marvin, Dorothy H. (12)
Marx, Frederick J. (2)
**Masciocchi, Thomas A. (7)**
Mason, Alvin S. (17)
**Mason, Howard B. (13)**
Mason, James H. (1)
Mason, Virgil A. (7)
Massengill, Fulton (7)
Massey, J. Bruce (7)
Masterson, John F. (7)
**Mastroianni, Frank M. (20)**
Mastromonaco, Joseph D. (9)
Masucci, Alberico (16)
Matera, Joseph (9)
Matheke, George A. (7)
Matheke, Otto G. (7)
**Matheke, Otto G., Jr. (7)**
Mathesheimer, Jacob L. (9)
Matheson, Gilchrist E. (7)
Mathews, Raymond H. (14)
Mathews, William J. (9)
**Matthews, Clifford B. (7)**
Matthews, Leonard M. (16)
Matthews, William (13)
Matthews, William F. (7)
Matturri, Dominick A. (9)
Maturi, Vincenzo E. (9)
Mauer, Richard E. (7)
Maurer, K. Virginia (7)
Maurer, Martha E. (20)
Maver, William W. (9)
**Maxwell, Carl A. (21)**
May, Ernst A. (7)
Mayhew, Charles H. (6)
Mazzarella, Carlo (16)
**McAlpine, Paul (20)**
McAveney, Thomas F. G. (7)
McBride, Andrew F. (16)
**McBride, Andrew F., Jr. (16)**
**McCall, Jesse (19)**
McCallion, William H. (20)
McCallum, Arthur S. (4)
McCandliss, William K. (11)
McCarroll, E. Mae (7)
McCarron, James A. (9)
McCarthy, Arthur M. (4)
McCarthy, Cornelius P. (9)
**McCarthy, George L. (16)**
**McCarthy, John J. (9)**
**McCarthy, William P. (11)**
McCauley, Francis J. (7)
McClintock, Elsie (20)
**McCluskey, Harry B. (14)**
McConaghy, Thomas P. (4)
McCorkle, William E. (10)
McCormack, Frank C. (2)
McCormick, James E. (7)
McCormick, William H., Jr. (12)
**McCreight, David W. (13)**
McCroskery, James H. (7)
McCue, John B. (16)
McCullough, John H. (11)
**McDermott, Vincent T. (4)**
McDonald, Richard J. (16)
McDonnel, Gerald E. (3)
**McDonnell, George J. (13)**
McFeely, Percy R. (2)
**McGeary, John A. (20)**
McGeehan, Stanley M. (1)
McGinn, William J. (20)
**McGlade, Thomas H. (4)**
McGovern, John F., Jr. (12)
McGuigan, Francis A. (11)
**McGuire, John J. (7)**
McGuire, Joseph T. (2)
McGuire, William A. (8)
McIlveen, Marion (2)
McKelvie, Julius C. (13)
McKeown, George H. C. (7)
McKiernan, Robert L. (12)
McKim, William F. (7)
McKinstry, John W. (12)
**McLane, A. Donald (2)**
**McLean, Hugh A. (9)**
McLellan, George A. (7)
McLeod, Neill S. (12)
McLoughlin, Frank J. (9)
**McLoughlin, John W. (9)**
McMahon, Bernard C. (14)
McMurray, George B. (14)
McMurtrie, William A. (14)
McNeely, Julia A. (7)
McNenney, Claudio E. (9)
McParland, Timothy W. (18)
**McPherson, Malcolm E. (16)**
McTague, Robert S. (13)
McVay, Edward A. (7)
McVeigh, Charles J. D. (19)
McWilliams, Charles E. (4)
Meacham, Eugene A. (12)
Means, Paul B. (11)
Mears, William G. (2)
Mecray, Paul M. (4)
**Mecray, Paul, Jr. (4)**
Medd, John C. (7)
Meehan, George E. (9)
Meehan, Martin M. (7)
Meeker, Irving A. (7)
Meeker, John L. (20)
**Megibow, Harold J. (2)**
Meier, William U. (16)
Meineke, William C., Jr. (20)
**Meinhard, Fred (7)**
Meinzer, Martin S. (12)
Meisel, David B. (7)
Mellen, Stanley H. (7)
Meloney, Lester F. (16)
Meltsner, Louis (9)
**Meltzer, Louis (9)**
Melvin, Daniel G. (14)
Mendenhall, Clinton D. (3)
Meneve, Alfred D. (16)
Menge, Carl H. (15)
Menk, Paul E. (7)
**Mensch, Harvey G. (20)**
Merendino, Anthony G. (1)
Merkelbach, Walter P. (7)
Merliss, Eugene (7)
Merlo, Francis A. (20)
**Merlo, Francis V. (20)**
Mermod, Camille (7)
Merrick, Evelina (7)
Merrill, Charles F. (12)
**Merrill, Edwin D. (10)**
Merselis, John G. (7)
Mersheimer, Christian H. (9)
**Messina, Thomas (7)**
Messinger, Samuel (12)
Metsky, Joseph (7)
**Metz, Henry (2)**
Metzer, Emma P. W. (3)
**Metzer, Freeman W. (3)**
Meurlin, Alfred (7)
MeVay, James C. F. (1)
**Meyer, Eugene A. (3)**
Meyer, George P. (4)
Meyer, Howard M. (2)
Meyer, William (9)
**Meyers, Francis R. (16)**
Meyerson, Noah (9)
Mezzetti, Alfred F. (6)
Michell, George E. (21)
**Michelson, Henry (16)**
Mick, Edwin C. (7)
**Mickewich, Stephen A. (9)**
Miele, Frank A. (13)
Mierau, Ernest W. (7)
Milano, Cesare A. (1)
Miller, Earle K. (11)
**Miller, George M. (12)**
Miller, Gerald H. (11)
Miller, H. Garrett (6)
**Miller, Herbert G. (2)**
**Miller, Herman P. (7)**
**Miller, I. Irwin (7)**
Miller, Joseph A. (7)
Miller, Lewis H. (17)
Miller, Lucille F. (7)
Miller, Max H. (9)
**Miller, Nathan (7)**
Miller, Ralph (7)
**Miller, Reginald C. (11)**
**Miller, Robert B. (9)**
**Miller, S. David (12)**
**Miller, S. Thomas (13)**
**Miller, Samuel R. (11)**
**Miller, Theodore R. (7)**
**Miller, William H. (17)**
Milligan, Robert S. (20)
Milliser, Estelle T. (20)
Mills, Charles S. (3)
Mills, Clifford (14)
**Mills, Stephen D. (20)**
Minard, Edwy L. (7)
**Minier, Carl L. (7)**
Miningham, William D. (7)
Minnefor, Charles A. (7)
**Minnella, Thomas J. (20)**
**Minschwaffer, Geo. G., Jr. (11)**
**Mintz, Alvin R. (9)**
**Mishell, Daniel R. (7)**
**Mishler, Jay E. (1)**
Misko, Albert (18)
Missonellie, William (16)
Mitchell, Augustus J. (7)
Mitchell, Charles H. (11)
Mitchell, Charles R. (16)
Mitchell, Walter L., Jr. (7)
**Mitchell, Willis B. (21)**

Mitskas, Theodore V. J. (11)
Mockett, Walter W. (2)
Modarelli, Walter H. (9)
Modeski, Chester J. (7)
**Modrys, Walter F. (2)**
Moeckel, Clarence W. (7)
**Mohair, John P. (13)**
**Molitch, Matthew (1)**
Monaco, Dante P. (7)
**Monaco, Saverio A. (7)**
**Monaloy, Morris A. (16)**
**Monfort, Robert N. (9)**
Monica, Louis A. (9)
Monosson-Friedland, Ida (5)
Monte, Thomas D. (14)
Moon, Alexander C. (5)
**Moore, Dean C. (7)**
**Moore, James A. (7)**
**Moore, Ralph L. (8)**
**Moran, John F., Jr. (10)**
**Mores, Herbert R. (2)**
**Moress, Edward J. (7)**
**Moretti, John J. (7)**
Morgan, Browne (7)
Morganstein, Louis K. (9)
Moriarty, John F. (9)
Morici, Theodore (16)
**Moriconi, Albert F. (11)**
Morley, Grace C. (9)
**Morrill, James P., Jr. (16)**
**Morris, Carlyle (12)**
Morris, David G. (9)
Morris, Karl E. (20)
**Morris, Nathan (18)**
Morris, Thomas M. (20)
Morris, Watson B. (20)
Morrison, Frederick H. (19)
Morrow, Joseph R. (2)
Moschkowitz, Hermann (7)
Moscoe, Harry A. (16)
Moss, Mary C. (7)
**Mott, Joseph E. (16)**
Motzenbecker, Peter F. (7)
Motzenbecker, William J. (7)
Mount, Walter B. (7)
Mountford, William E. (11)
**Muccia, John J. (9)**
Mueller, George H. (9)
**Muldoon, Edward J. (3)**
Muller, Frederick L. (2)
Muller, Joseph H. (7)
Mulligan, Edward W. (13)
**Mulligan, Luke A. (2)**
Mullin, Eugene F. (7)
Mullin, Raymond J. (7)
Mullins, Roy L. (10)
Mulvihill, William J. (9)
Munger, Ray T. (20)
Munro, Charles A. (3)
Munro, Jeannette (11)
Murn, Charles J. (16)
Murphy, Albert T. (20)
Murphy, Charles M. (13)
Murphy, Herschel S. (20)
Murphy, James A. (11)
Murphy, James M. (9)
Murphy, Leo J. (9)
Murphy, Patrick H. W. (9)
**Murphy, Thomas W., Jr. (7)**
**Murray, Clifford K. (1)**
**Murray, Edwin N. (4)**
Murray, Harrold A. (7)
Murray, Joseph A. (9)
**Murray, Norman L. (20)**
Murto, Thomas V. (11)
**Musetto, Carmelo A. (14)**
**Mustermann, Otto H. (9)**
Muta, Samuel A. (7)
Mutchler, H. Raymond (14)
Muttart, George W. (9)
Mutter, Alfred A. (9)
Myatt, Leslie E. (6)
**Myers, Norman V. (2)**

ASSOCIATE MEMBERS

MacGahan, William H. (16)
**Mancusi-Ungaro, Harold (7)**
**McCracken, Josiah C., Jr. (1)**
McGahn, Joseph (1)
McLaughlin, William B. (7)
Mele, Vincent (7)
Modny, Michael T. (7)
Morris, Leroy, Jr. (11)

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# N

ACTIVE MEMBERS

Nacca, Carl A. (7)
**Nadel, Charles I. (7)**
**Nadler, Arthur A. (20)**
**Nafash, Shafeek (9)**
Nafey, Herbert W. (12)
**Nagler, Benedict (7)**
**Naidorff, Saul A. (20)**
Nalitt, David I. (9)
**Nappi, Pasquale E. (7)**
Nash, Alexander E. (7)
Nash, Herman S. (7)
**Nataro, Joseph (7)**
Naulty, Charles W., Jr. (12)
**Navazio, Attilio (14)**
Nayfield, Romald C. (11)
Neal, Charles B. (6)
**Neary, Edward R. (2)**
Neer, William (16)
Neiderhoffer, Sydney L. (13)
**Nelman, Watson E. (15)**
Nelson, Harry (8)
Nemirow, Martin (16)
Nemzek, William P. B. (7)
Nesbitt, Elizabeth (16)
**Netz, Lester W. (2)**
Neville, Robert J. (2)
**Nevius, William B. (7)**
Newbury, Graham C. (20)
Newcomb, Marcus W. (3)
Newman, Abraham J. (9)
Newman, Grace T. (7)
**Newmeyer, Joseph (3)**
**Ney, J. Marshall (7)**
Nichols, Frank I. (2)
Nichols, Stanley H. (13)
Nicholson, Frank P. (9)
**Nickman, E. Harrison (1)**
Nicol, Lorenz C. (2)
Nicola, Toufick (7)
**Nicoll, George L. (14)**
Nieman, Solomon Z. (12)
**Niemtzow, Frank (13)**
**Nimaroff, Meyer (7)**
Nittoli, Rocco M. (20)
**Nobile, James J. (9)**
Noll, Louis (7)
Nonziato, Frank A. (11)
**Normand, Alphonse F. (12)**
North, Harry R. (11)
Norton, James F. (9)
Norval, William A. (16)
**Notkin, Meyer (16)**
Noto, Philip (16)
**Novello, Joseph A. (20)**
**Novich, Max (7)**
Nuse, Edward F. (9)
**Nussbaum, Harvey E. (7)**
**Nussbaum, Joseph (20)**
Nye, Howard H. (16)
Nyirl, William A. (7)
**Nyvall, Pierre J. (15)**

ASSOCIATE MEMBER

**Nussbaum, Nathan (16)**

# O

ACTIVE MEMBERS

Oberlander, Gertrude (7)
Obert, J. Edwin (15)
Obester, Gabriel E. (20)
O'Brian, Dennis M. (16)
O'Brian, Jeremiah H. (16)
**O'Brien, Edwin J., Jr. (20)**
Ockene, Abraham (9)
**O'Connell, James J. (12)**
O'Connor, Bernard A. (7)
O'Connor, Dennis F. (7)
O'Connor, John J. (9)
O'Connor, Michael J. (7)
**O'Connor, Paul A. (7)**
O'Crowley, Clarence R. (7)
Oderr, Charles (20)
**Oesterlin, Ernst J. (1)**
Oesterrelcher, Desider (9)
**Offenkrantz, Frederick M. (7)**
Ogden, Andrew E. (11)
Ogden, Michael A. (16)
**O'Grady, Michael J. (7)**
O'Hanlon, George (9)
Okin, Irving (16)
Olini, Joseph J. (7)
O'Lini, Louis J. (7)
Olpp, Archibald E. (9)
**Olpp, John L. (2)**
Olson, Vendela E. (2)
Ondovchak, M. Frederic (4)
O'Neill, Charles L. (7)
**O'Neill, Charles L., Jr. (7)**
O'Neill, Gonzalo, Jr. (7)
O'Neill, Joseph F. (11)
Opdyke, Gordon M. (7)
Openchowski, Mieczyslaw (7)
**Opper, Philip (16)**
Oram, Joseph H. (16)
Oransky, Marvin (7)
Oren, Hyman (2)
Orloff, Samuel (7)
Ormsby, Thomas J. (7)
**Ornaf, I. Edward (4)**
O'Rourke, James J. (11)
**Orris, Harold J. (7)**
**Ortolano, James J. (9)**
**Orton, Foster (20)**
Orton, George L. (20)
Orton, Henry B. (7)
**Orton, Stuart (20)**
Osborn, A. Downey (13)
**Osborn, Edward G. (4)**
**O'Shea, John J. (9)**
Osher, Morris M. (20)
**Oshrin, Henry (9)**
**Ostrowski, Sigismund J. (7)**
O'Sullivan, John R. (9)
**Outwin, Richard N. (7)**
Owen, Logan S. (9)
**Owen, Philip (20)**

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# P

ACTIVE MEMBERS

**Padden, Aloysius F. (2)**
Paddock, Royce (7)
Pagano, Peter (2)
Pagliughi, John J. (9)
**Palazzo, William L. (14)**
**Pallen, Conde deS. (2)**
**Palma, Nicholas (16)**
Palmer, Francis R. (16)
Palmer, Gideon H. (7)
Palmer, Henry S. (7)
**Panigrosso, Louis R. (12)**
Panitch, William (7)
Pannullo, John N. P. (7)
Pansy, Abraham A. (12)
Pantaleone, Joseph (11)
**Papera, John J. (7)**
**Parell, George C. (7)**
**Parent, Sol (7)**
**Paris, William (16)**
**Parker, Albert F. (17)**
Parker, Horace N. (11)
Parker, James W. (13)
Parker, John E. (7)
Parkes, Morey (7)
**Parry, Allen A. (14)**
Parry, Antoinette R. (14)
Parry, Oliver K. (13)
Parsonnet, Aaron E. (7)
**Parsonnet, Eugene V. (7)**
Pascall, Thomas M. (7)
**Pasternack, Elroy (16)**
Patella, Fulvio (16)
Patterson, Isaac N. (8)
**Patti, Frank A. (2)**
**Pattyson, Ralph A. (7)**
Paul, George A. (7)
**Paul, H. Carl (7)**
Paulson, Arch M. (20)
**Pavia, John R. (7)**
Payne, Guy (7)
**Payne, Guy, Jr. (7)**
Peacock, Arthur B. (3)
**Pearl, Sydney S. (20)**
Pearlstein, Frank (9)
Pearson, J. Gerald (12)
Pearson, Theodore A. (18)
Peckman, Abram (9)
Pecora, Carmine L. (15)
**Pecora, Samuel (7)**
Pedevill, Joseph R. (2)
Pedrick, William W. (8)
Peer, Lyndon A. (7)
Pellegrini, Vincent J. (2)
Pellet, Thomas L. (19)
**Pellicane, Anthony J. (12)**
**Pelliciari, Donald (7)**
**Penchansky, Samuel J. (9)**
Pendexter, Sidney E. (7)
Pennington, Alfred W. (7)
Pennington, John (1)
Pentecost, Salvador D. (7)
Pentel, Louis S. (9)
Perelman, Julius S. (7)
Perez, John F. (1)
**Perham, Bertram S. (7)**
Perham, Roy G. (2)
Perkel, Louis L. (9)
Perlberg, Harry J. (9)
**Pernetti, Anthony M. (16)**
**Perrine, Cornelius C. (13)**
**Perrone, Arthur F. (9)**
**Perrotta, Anthony J. (13)**
**Perry, Frank L. (17)**
Pessel, Johannes F. (11)
Peters, Edgar A. P. (9)
Peters, Menelaus (9)
**Peters, Richard C. (20)**
Peterson, Charles A. (9)
Peterson, Walter R. (11)
Petry, William (7)
Pettit, Harry H. (2)
Pettit, Herschel (5)
Phelan, Walter F. (20)
Phelps, James E. (16)
Phillips, Algernon A. (7)
Phillips, Claude B. (4)
Phillips, Walter (2)
**Piasecki, Chester A. (16)**
**Pieper, Howard C. (13)**
**Pierce, Henry A. (2)**
Pierson, Carl L. (11)
**Pierson, Joseph R. (11)**
Pietri, Raoul (13)
**Pignataro, Frank P. (13)**
Pigott, Albert W. (18)
Pike, Charles E. (4)
Pilch, Arthur G. (7)
Pilkington, Albert (1)
Piller, Jacob (16)
**Pilloni, Louis (7)**
**Piltz, George F. (9)**
Pinckney, Frank H. (14)
Pincus, Isidore (7)
**Pindar, Arthur W. (2)**
Pindar, Frederick S. (9)
Pindar, Irene D. (2)
Pindar, William A. (9)
Pinerman, Robert B. (11)
Pingitore, Eufelia (2)
**Pink, Solomon H. (16)**
**Pino, Anthony (6)**
**Pinsky, Harry A. (4)**
**Pinto, Joseph A. (7)**
Piskorski, Abdon V. (9)
Pitkin, Winifred (2)
Pitman, Mason W. H. (18)
Pittman, Allen R. (11)
**Pizzi, Francis W. (7)**
**Pizzi, Mario V. (7)**
**Pizzi, Peter J. (2)**
Plant, James S. (7)
**Plante, Amos A. (7)**
**Platt, Edward V. (4)**
Platt, Thomas H. (12)
Plavin, Nathan J. (9)
**Pleasants, Edward N. (13)**

Plinke, Fritz W. (16)
Plume, Clarence A. (14)
Podell, A. Alfred (13)
Pogoloff, Samuel H. (18)
**Pois, John (7)**
Poland, George A. (1)
Polaner, George (7)
Poleshuck, Rubin (20)
**Policastro, Nelson C. (2)**
Polizzotti, Joseph L. (16)
Polk, Charles C. (20)
**Pollack, Louis (20)**
Pollak, Berthold S. (9)
Poller, Frederick K. (7)
Pollis, Nicholas L. (7)
**Pollock, Samuel L. (14)**
**Pollock, Theodore (16)**
**Polow, Benjamin (7)**
Polowe, David (16)
**Pomeranz, Raphael (7)**
**Pons, Carlos A. (13)**
Pontery, Herbert B. (9)
**Potter, Benjamin P. (9)**
Potter, Charles W. (21)
Potter, Ellen C. (11)
Potter, Raymond T. (7)
Pottinger, William E. (14)
Povalski, Alexander W. T. (9)
Powis, Ethel M. (11)
Poyas, Morton L. (11)
Prager, Bert A. (14)
Prall, Henry E. (2)
**Prather, Charles G. (2)**
Prather, John W. (2)
Pratt, Arthur G. (4)
Prazak, Beatrice (20)
**Preece, John D. (11)**
Pregnall, James P. (13)
Preminger, Max (20)
Prestifilippo, Silvestro (7)
Preston, Perry B. (7)
Price, Charles W. (7)
**Price, H. Preston, (9)**
**Price, Henry S., Jr. (4)**
Price, Nathaniel G. (7)
Prigger, Edward R. (17)
**Prince, Robert A. (16)**
**Prince, Samuel (9)**
Principato, Roberto (4)
**Probst, Everett W. (7)**
Proctor, Francis E. (11)
Proctor, Jesse E. (7)
**Protzman, Thomas B. (2)**
Proudfoot, Perry A. (20)
Prout, Thomas P. (20)
Prout, William B. (2)
Provisor, Benjamin (16)
Pullen, Guy F. (2)
Purcell, Ernest F. (11)
Purdy, Charles H. (9)
Pyle, Louis A. (9)
Pyle, Wallace (9)

ASSOCIATE MEMBERS

Pramuk, Clarence (2)
Putter, Eric (12)

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# Q

ACTIVE MEMBERS

**Quad, Clifford W. (7)**
Quaglieri, Charles L. (9)
Quigley, Frederic J. (9)
Quin, John A. (20)
Quinn, Edward D. (7)
Quinn, John J. (9)
Quinn, Norman J. (1)
**Quirk, Martin A. (13)**

ASSOCIATE MEMBER

Quackenbos, Harrie M. (11)

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# R

ACTIVE MEMBERS

**Raab, Michael (16)**
Rabinowitz, Jacob H. (7)
**Rachlin, Harry T. (7)**
Rachunis, Michael (3)
Rader-Hoheb, Katherine A.(2)
Radest, Louis J. (16)
Rados, Andrew (7)
**Raffetto, Joseph F. (13)**
Ragany, Joseph (11)
Ragione, Mario D. (7)
**Rainey, Willard G. (11)**
**Ram, Nathan H. (7)**
**Rampona, Joseph M. (11)**
Ramsey, F. Muriel (6)
Randazzo, Anton P. (16)
Ranson, Briscoe B., Jr. (7)
**Rapalski, Adam J. (7)**
Rapp, Robert F. (4)
Rathgeber, Charles F. (7)
**Rauschenbach, Paul E.,Jr. (16)**
**Ravits, Everett C. (2)**
Ravitz, Israel (7)
**Ravitz, Samuel F. (7)**
Rawitz, Sidney B. (7)
Re, Natale M. (2)
Read, Donald B. (9)
**Read, Hilton S. (1)**
**Read, Jessie D. (20)**
Read, William T., Jr. (4)
Reading, H. Eugene (16)
Reale, Frank P. (20)
Reale, Nicholas P. (18)
Reason, John J. (12)
Reeve-Allen, Jane (7)
Reeves, Ernest (16)
Reeves, J. Franklin (6)
Reich, Abraham L. (7)
**Reich, Henry (7)**
Reich, Jerome J. (20)
**Reich, Mortimer (7)**
Reich, Samuel B. (2)
**Reilly, Christopher J. (7)**
Reilly, David F. (20)
**Reilly, John V. (7)**
**Reilly, Thomas F. (16)**
**Reinartz, Paul V. (7)**
**Reiner, David N. (16)**
Reiner, Jacob (20)
Reinfeld, Abraham G. (7)
Reingold, Alexander (9)
**Reinhardt, Warren I. (7)**
Reinhold, Herbert E. (2)
**Reinhorn, Abraham J. (16)**
Reisinger, Paul B. (11)
Reissman, Erwin (7)
Reiter, Walter A. (20)
**Reitman, Norman (12)**
**Relyea, George M. (20)**
Remer, Daniel F. (3)
Remondelli, Raphael E. (7)
Renna, Francis (14)
Renner, Clara C. (18)
Renzulli, Francesco (7)
**RePass, Paul E. (7)**
Repici, Anthony J. (1)
**Resch, Henry U. (7)**
**Restaino, Charles F. (7)**
Rettig, Isidor L. (7)
**Revere, Seth D. (7)**
Reyner, Daniel C. (1)
**Reynolds, Donald G. (13)**
Reynolds, George G. (13)
**Reznikoff, Leon (9)**
**Rhoads, S. Creadick (8)**
Rhone, David S. (4)
Ribbans, Robert C. (7)
Riccobono, Cosmo S. (16)
Rice, Franklin W. (14)

Rich, Charles (7)
Rich, Harry H. (7)
**Rich, Wallace E. (7)**
Richards, Ernest W. (2)
Richardson, Charles A. (2)
Richardson, Emma M. (4)
**Richardson, Marvin T. (7)**
**Richlin, Padie (12)**
Ricketts, Henry E. (7)
**Rieck, Allan (1)**
Rieck, Walter R. (9)
**Riegert, Louis C. (4)**
**Rieman, Aloysius P. (9)**
Riese, Jacob A. (9)
**Riffin, Irving M. (7)**
Riggins, Edwin N. (7)
Riggs, Vincent J. (7)
**Riley, Philetus H. (14)**
**Rineberg, Irving E. (12)**
**Ringe, Charles L., Jr. (2)**
Ringewald, Robert H. (2)
Rink, William E. (3)
**Rinzler, Elliot (7)**
Rinzler, Harry G. (16)
**Rinzler, Harvey (15)**
Ripley, E. Warren (7)
**Rise, Wilson S. (1)**
**Ristine, Edwin R. (4)**
Rita, James J. (11)
Ritter, John J. (16)
Rizzoli, Luigi (7)
Rizzolo, Edward M. (7)
Robbin, Lewis (7)
Robbins, Charles M. (7)
Robbins, Eugene (7)
**Roberts, Allison H. (7)**
**Roberts, Charles D. (2)**
**Roberts, David C. (7)**
Roberts, Joseph E., Jr. (4)
Roberts, William A. (7)
**Robertson, Eugene V. (16)**
**Robertson, Euston S. (7)**
Robertson, Grace M. (20)
Robie, Theodore R. (7)
Robins, David (7)
Robinson, Anne W. (20)
Robinson, Ernest A. (13)
Robinson, Louis H. (7)
Robinson, Silas E. (2)
Robinson, William A. (13)
Rocco, Frank (7)
**Rodman, E. Warren (3)**
Roemer, Jacob (16)
Rogers, Dorothy M. (8)
Rogers, Harry L. (3)
Rogers, Laurence H. (11)
**Rogers, Richard M. (7)**
Rogers, Robert H. (7)
**Roh, Robert F. (7)**
Romano, Anthony M. (2)
**Romano, Michael J. (16)**
Romano, Patrick J. (7)
Rommer, Jack J. (7)
Rona, Maurice (12)
Rooks, Wendell H. (2)
Roop, William O. (1)
Rosamilia, Ralph E. (7)
Rose, Abraham (20)
**Rose, William G. (11)**
**Roseman, Herman I. (7)**
**Rosen, Charles D. (7)**
**Rosen, Charles E. (9)**
**Rosen, Emanuel (7)**
**Rosen, Sol (6)**
**Rosenbaum, Samuel X. (7)**
**Rosenberg, Albert B. (9)**
**Rosenberg, Alvin A. (14)**
Rosenberg, Jacob (9)
Rosenberg, L. Charles (7)
**Rosenberg, Louis (1)**
**Rosenberg, Max (7)**
**Rosenblatt, Max B. (20)**
Rosenblatt, Sidney (1)
Rosenstein, Jacob L. (9)
Rosenstein, Saivel L. (20)
**Rosenthal, Abraham (13)**
Rosenthal, Arnold J. (7)
**Rosenthal, Bernice D. (6)**
Rosenthal, Oscar J. (7)
**Rosenthal, Sydney (7)**
**Ross, Peter W. (16)**
**Ross, Selig J. (2)**
Rossi, Bartolomeo (18)
**Rossi, Gene (18)**
Rost, Adolf S. (7)
Roth, Ferdinand L. (20)
Rothfuss, C. Howard (12)
**Rothgesser, Jerome C. (7)**
**Rothhouse, Burnet (7)**
**Rothschild, Daniel L. (7)**
Rothschild, Karl (12)
Rothseid, Abraham (7)
Rowan, Henry M. (11)
Rowe, Jack M. (7)
Rowe, Joseph A. (2)
Rowland, John H. (12)
Roy, Bert W. (19)
Roy, Joseph N. (16)
**Roylance, F. Dean, Jr. (2)**
Rozsa, Stephen (7)
RuBacky, Joseph F. A. (16)
**Rubba, Russell R. (1)**
**Rube, Joseph A. (2)**
**Rubens, Otto (14)**
Rubenstein, Eli (9)
**Rubenstein, Robert (9)**
**Rubin, Abraham A. (7)**
Rubin, Adrian D. (13)
**Rubin, Benjamin (12)**
Rubin, David (20)
**Rubin, Harold (13)**
**Rubin, Samuel (14)**
**Rubin, William (12)**
Rubino, Nicholas M. (7)
**Ruccia, Arthur (7)**
Rucker, William C. (2)
**Rudolph, John P. (4)**
**Ruffer, Ralph A. (9)**
Rullman, Walter A. (13)
Rumage, William T. (7)
Rumsey, William L., Jr. (20)
Rundlett, Emilie V. (9)
Runnells, John E. (20)
Runyan, William J. (7)
Runyon, Laurence P. (12)
**Ruocco, William B. (16)**
Ruoff, Andrew C. (9)
Russell, Charles B. (16)
Russell, David L. (9)
**Russell, Karl S. (4)**
Russo, Dominic T. (18)
**Russomanno, Raymond L. (7)**
**Ruttenberg, Louis (8)**
Ruttenberg, Max (4)
Ruvane, Joseph J. (9)
Ryley, Harold W. (2)
Ryman, Merlin T. (14)

ASSOCIATE MEMBERS

**Racz, George (12)**
Rappaport, Doris I. (2)
**Rogers, James A. (16)**
**Roston, Mark A. (7)**

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# S

ACTIVE MEMBERS

Sabarese, Theodore C. (16)
**Sabini, Cecil F. (9)**
Sacco, Anthony G. (9)
Sacco, Gregory E. (13)
Sachs, Wilbert (9)
**Sackin, Stanley (11)**
**Sadoff, Joseph (20)**
**Saffron, Morris H. (16)**
Sager, Harold (9)
Sagi, Ellen I. (20)
Sakowski, John P. (9)
Sala, Aldo W. (16)
Saladino, Anthony J. (9)
Salaky, William L. (12)
Salasin, Samuel L. (1)
**Salmeri, Edward J. (2)**
Salmon, Edward F. (9)
Salmon, George G., Jr. (7)
Salmon, Leon T. (10)
Salsberg, Ralph H. (7)
Salter, Kent (16)
**Saltus, Lloyd S. (14)**
Salva, Edo J. (2)
Salvati, Leo H. (20)
Salvatore, Joseph T. (11)
Salway, Benjamin (11)
Salzman, Nathan (16)
Samson, Norman D. (7)
**Samter, Max (4)**
**Samuel, Jerome H. (7)**
**Samuels, S. Lawrence (20)**
**Sand, Abraham B. (3)**
Sandella, Joseph F. (12)
Sandler, Moses (2)
**Sandler, Samuel A. (2)**
Sanfacon, Thomas A. (16)

**Santangelo, Emil L. (16)**
Santangelo, Stephen (9)
Santor, Daniel (4)
Santora, Philip J. (7)
**Santoro, Thomas A. (7)**
**Santosky, Benjamin B. (9)**
Saporito, Archibald R. (7)
Saracino, Frank J. (7)
**Saradarian, Albert V. (9)**
Sarajian, Aram M. (2)
Sargent, Eva R. (18)
Sarla, Michael (2)
Sarokhan, Joseph (16)
Saslow, Benjamin I. (7)
Saslow, Stella K. (7)
**Satulsky, Emanuel M. (20)**
Saulsberry, Charles E. (12)
Saunders, Orris W. (4)
Savage, Charles L. (17)
Savel, Lewis E. (7)
Sawyer, Blackwell (15)
**Sax, Max T. (7)**
**Sayers, Francis P. (17)**
Sayre, William D. (13)
Sbarra, Francesco C. N. (7)
**Scalera, John F. (7)**
Scalessa, Mario F. T. (20)
Scammell, Frank G. (11)
Scanlan, D. Ward (1)
Scasserra, Benedict B. (11)
Scerbo, Ernest (2)
Schaaf, Royal A. (7)
**Schaberg, Frank J. (2)**
**Schachter, Harry A. H. (7)**
Schaefer, Eugene P. (7)
Schafer, Marguerite A. (16)
Schaffer, Barney (7)
**Schaffer, Nathan (7)**
Schall, Reuben E. (4)
Schapiro, Joseph (9)
Schectman, Vera (7)
Scheer, Eli (9)
Scheffler, Wilhelm A. H. (4)
Schefrin, Alexander E. (16)
**Schellenger, Edward A. Y. (4)**
**Scheller, George A. (7)**
Schenk, Joseph R. (20)
**Schenker, Benjamin N. (9)**
Schenker, Israel N. (9)
Schept, Samuel S. (9)
Scher, Maurice A. (7)
Schildkraut, Jacob M. (11)
Schiller, Edwin (20)
Schiller, Nicholas (7)
Schiller, Rosa O. (20)
Schilling, Anthony B. (20)
**Schirber, Rene G. (12)**
Schiro, S. Robert (2)
Schisler, Milton M. (3)
Schlein, August (9)
Schlein, David (20)
Schlichter, Charles H. (20)
**Schlossbach, Theodore (13)**
Schlossberg, Ezra (16)
**Schmidt, Albert F. (13)**
Schmidt, Clifford M. (19)
Schmidt, Walter W. (2)
Schneider, Charles A. (7)
**Schneider, Clinton R. (15)**
Schneider, Harry M. (9)
Schneider, Louis (7)
Schneider, Louis A. (9)
**Schneider, Richard C. (7)**
Schoenau, Carl W. (7)
Schotland, Clement E. (7)
Schrack, Helen F. (4)
**Schram, William S. (18)**
Schramm, Joseph A. (7)
Schreck, Harry (7)
Schretzmann, Rudolph C. (2)
**Schubert, Roy R. (16)**
Schuchner, William F. (9)
Schuck, Traugott J. (9)
Schulman, Abraham S. (9)
Schulsinger, Samuel (7)
Schulte, Herbert A. (7)
Schults, Anna R. (7)
Schultz, Augustin M. (16)
Schultz, Irving A. (2)
**Schurman, Francis H. C. (7)**
**Schwartz, Harold (7)**
**Schwartz, Harold B. (9)**
**Schwartz, Henry C. (4)**
**Schwartz, Jacob R. (16)**
**Schwartz, Leon J. (6)**
**Schwartz, Mortimer L. (7)**
**Schwartz, Ralph A. (7)**
**Schwartz, Samuel H. (20)**
Schwartz, William (16)
**Schwartzberg, Frederick I. (16)**
Schwarz, Berthold T. D. (9)
**Schwarz, Henry J. (9)**
Schwarz, John (9)
Schwarz, Julianna L. (16)
Schwarzkopf, George C. (1)
**Schwarzwald, Irving (9)**
**Schweizer, Roman G. (20)**
Schwinn, Charles (1)
Sciarrillo, Louis F. (9)
**Scielzo, Nicholas F. (16)**
**Scillieri, John (2)**
Sciorsci, Edward F. (9)
Scott, Frederick J. (19)
Scott, Frederick W. (12)
**Scott, John J. (9)**
Scott, Leonard G. (6)
Scott, Norman M. (7)
Scott, Parry M. (3)
Scott, R. Hunter (7)
Scott, Samuel G. (9)
Scranton, Charles W. (7)
Scribner, Charles H. (16)
Scullion, Arthur A. (2)
Sealey, Henry J. (2)
Seeler, Albert O. (20)
Seely, Roy B. (11)
Segard, Christian P. (2)
Seiberling, Joseph D. (4)
Seidler, Victor B. (7)
Seidman, Edwin A. (7)
**Seidman, Joshua I. (7)**
Seifert, Edwin A. (7)
Seiler, Benjamin (2)
Seitzick-Robbins, Hannah E. (11)
Sekerak, Albert J. (11)
Seligmann, Fred S. (9)
Selinger, Samuel (9)
Sell, Frederick W. (20)
Sellitto, Anthony M. (7)
Selvaggi, Carlo (7)
Sena, Dominic R. (20)
Sena, Marie A. (7)
Sender, Fannie (12)
**Senerchia, Fred F., Jr. (20)**
Serri, William S. (8)
**Seto, Stanford P. T. (4)**
**Severud, Olaf J. (2)**
Seward, Frederic H. (14)
Seward, William H. (7)
Sewell, Stephen (13)
**Sexton, Edward V. (2)**
**Seybold, Arthur D. (20)**
Seymour, Edward T. (2)
Seymour, George A. (20)
Shack, David N. (7)
**Shack, Maxwell H. (7)**
**Shaen, Edward (4)**
**Shafer, Albert H. (4)**
Shafer, F. William (4)
Shaner, Ralph D. (7)
Shangle, Milton A. (20)
**Shangold, Jack E. (10)**
**Shanik, Morton J. (14)**
**Shanik, William (13)**
Shannon, James B. (7)
Shannon, Lardner M. (7)
Shapiro, Charles S. (3)
Shapiro, David (16)
Shapiro, Louis (7)
Shapiro, Louis G. (16)
Shapiro, Nathaniel J. (9)
**Shapiro, Ralph N. (7)**
**Shapiro, Samuel A. (7)**
**Shapiro, Saul J. (9)**
Sharp, Charles E. (6)
**Sharp, Reuben L. (4)**
Shaul, Frederick G. (7)
**Shaul, John F. (7)**
**Shavelson, Irving C. (1)**
Shaw, Ernest B. (4)
Shaw, John J. (7)
**Shaw, Ned (7)**
Shayevitz, Abraham S. (12)
Sheaffer, Clinton P. (4)
Shear, M. Murray (11)
**Shechner, Isadore (7)**
Shechtman, Abraham (16)
**Sheehan, Daniel C. (7)**
Sheeran, Vincent J. (9)
Sheets, Cecil C. (8)
Sheft, Matthew J. (16)
Shemeley, William G., Jr. (4)
Shenfeld, Isaac (1)
Sheppard, Alfred G. (6)
Sheppard, Muse A. (6)
Sheppard, Thomas S. (6)
Sherk, A. Lincoln (4)
Sherman, A. Russell (7)
**Sherman, Arthur E. (7)**
**Sherman, Benjamin (14)**
Sherman, Byron G. (14)
Sherman, Elbert S. (7)
Sherman, Fuller G. (8)
**Sherman, Samuel H. (20)**
Sherman, William E. (12)
Shevitz, David M. (21)
**Shill, Benjamin (7)**
Shimer, Floyd A. (21)
Shinefeld, Maurice A. (16)
Shipman, James S. (4)
Shipman, Meyer P. (16)
Shippee, James N. (16)
Shipps, Hammell P. (3)
**Shirlock, Margaret E. (6)**
Shirrefs, Russell A. (20)
Shivers, Charles H. deT. (1)
**Shlionsky, Herman (7)**
Shook, Benjamin E. (9)
Shope, Edward P. (4)
**Shor, David M. (7)**
**Shreehan, Hubert F. (7)**
Shull, Elliott C. (4)
Shull, John V. (12)
Shulman, Abraham (16)
**Shulman, Murray W. (7)**

Shulman, Nathan L. (9)
**Shuster, Samuel A. (1)**
Sica, L. Samuel (11)
**Sickel, Emanuel M. (15)**
**Siddall, John R. (3)**
Sieber, Isaac G. (4)
Siegel, Isadore (12)
**Siegel, Jack G. (7)**
Siegel, Jacob W. (7)
**Siegel, Lester (9)**
Siegel, Sidney L. (6)
Siemion, Theophilis R. (11)
Sigman, George (9)
**Silberner, Herbert B. (7)**
**Silich, Robert L. (9)**
Silk, Charles I. (12)
Sill, John B. (11)
Silver, E. Drew (11)
**Silver, Harry B. (7)**
Silverman, Irving A. (16)
Silverman, R. Louis (17)
**Silverman, S. Andrew (7)**
Silvers, Homer I. (1)
Silverstein, Benjamin J. (7)
Silverstein, Jacob M. (7)
**Simeone, Peter A. (9)**
Simkin, Abraham (16)
Simmons, Albert V. (7)
Simms, George F. (7)
**Simon, Henry (7)**
**Simon, Julius J. (16)**
**Simon, Ludwig L. (7)**
Simon, Philip H. (16)
Simonson, Louis (7)
**Simpson, David B. (9)**
Sims, Richard V., Jr. (20)
Sinexon, Henry L. (8)
Singer, Bella (20)
Singer, Marie J. (2)
Singer, Max (7)
Singer, Sina S. (9)
Sinkinson, Charles D., Jr. (1)
Sinnott, Gerald W. (9)
Sinton, John Y. (11)
**Sirotta, E. Bernard (8)**
Sisson, Nelson W. (7)
Skrypski, Joseph M. (9)
Skvarla, John A. (2)
Skwirsky, Joseph (7)
Slack, Clarence J. (11)
Slaff, Florence (16)
Slavin, Paul (7)
Sloan, Samuel L. (16)
Slobodien, Benjamin F. (12)
Slocum, Harry B. (13)
Sly, John L. (20)
**Smaine, Enrique delC. (2)**
Small, E. Lester (3)
**Small, Louis (16)**
Smalley, Sara D. (7)
**Smalzried, Elmer W. (7)**
Smarzo, Marjorie M. (7)
Smith, Andrew M. (1)
**Smith, Arthur B. R. (9)**
**Smith, Bertram H. (4)**
Smith, Bryan A. (2)
**Smith, Byron J. (7)**
**Smith, Charles H. (7)**
Smith, Christopher A. (7)
**Smith, Edward C. (15)**
Smith, Ellis L. (7)
Smith, Elroy W. (16)
Smith, Frank W. (11)
Smith, Harold W. (7)
Smith, Henry G. (7)
**Smith, Herman (21)**
Smith, Ivan B. (12)
**Smith, J. Meredith (21)**
Smith, James D. (4)
Smith, John A. (12)
Smith, John V. (12)
Smith, Joseph A. (12)
Smith, Joseph J. (7)
Smith, Leon A. (16)
Smith, Leonard H. (7)
Smith, Malcolm K. (14)
Smith, Marcia V. (5)
Smith, Nehemiah E. (2)
Smith, Nelson M. (7)
**Smith, Percy L. (12)**
**Smith, Sydney F. (12)**
Smith, Thayer A. (7)
Smith, W. Henley (11)
**Smith, Wilbur A. (4)**
**Snagg, William T. (4)**
Snape, William J. (4)
Snavely, Earl H. (7)
**Snedecor, Spencer T. (2)**
**Snegireff, Leonid S. (11)**
Snook, Lee O., Jr. (7)
Snyder, W. Jay (9)
Sobel, I. Jerome (16)
**Sobin, Julius (7)**
Sochacki, Alexander (4)
**Sokoloff, Oscar J. (12)**
Solk, Arthur G. (7)
Solomon, Harold (7)
Solomon, Louis (9)
**Solworth, Lee (2)**
Somers, Fred L. (7)
**Somers, Williard H. (2)**
Sommer, George N. J. (11)
**Sommer, George N. J., Jr. (11)**
**Sonnenberg, Arthur (7)**
Sooy, L. Thomas (8)
Sorock, Emil M. (7)
Soschin, Samuel J. (7)
Sosnow, Louis M. (2)
**Spagnolo, Peter J. (12)**
**Spaldo, John L. (18)**
Spallone, Joseph C. (7)
**Spano, Frank (9)**
**Sparks, Paul R. (3)**
**Spath, William H. (9)**
Spencer, Alvan (14)
**Spencer, James H., Jr. (19)**
**Sperling, Irving L. (7)**
Spickers, William (16)
**Spicola, Louis A. (2)**
Spiegelglass, Abraham B. (2)
Spillane, Timothy H. (21)
Spinner, Samuel L. (7)
**Spirito, Michael W. (20)**
**Spivack, David (20)**
**Spohn, Eugene L. (9)**
Spradley, Jeems B. (11)
Sprague, Edward W. (7)
Sprague, Seth B. (9)
Spranz, William S. (2)
**Spritzer, Theodore D. (12)**
Spurgeon, Dorsett L. (19)
Stabile, John A. (11)
Staehle, Richard H. (7)
**Stage, Earl DeW. (14)**
Stahl, Alfred (7)
Stahl, Charles (7)
Staknevich, John H. (7)
**Stamps, G. Ruffin (1)**
**Stankiewicz, F. Stanley (9)**
Stanton, Nathaniel B. (20)
Stark, Jacob (16)
Starr, Benjamin (9)
Stassi, Anthony (2)
Statman, Arthur J. (7)
**Staub, E. Milton (20)**
**Steel, John M. (11)**
Steel, William A. (5)
Steele, Stephen (20)
**Stefansin, Frank (9)**
**Steffens, Charles T. (12)**
Stein, Albert (9)
Stein, Emil (20)
**Stein, George H. (20)**
Stein, Harold M. (16)
Stein, Isadore (20)
Stein, Jacob M. (9)
**Stein, Joseph M. (4)**
Stein, Louis A. (11)
Stein, Martin H. (20)
**Stein, William (12)**
**Steinberg, Benjamin L. (16)**
**Steinberg, Werner (20)**
Steiner, Edwin (7)
Steiner, Herbert (7)
**Stephenson, Daniel H. (4)**
Stephenson, Gordon A. (20)
Stern, David A. (7)
Stern, Max E. (7)
**Stern, Morris H. (16)**
Stern, Morton M. (7)
**Stetser, Leland M. (4)**
Stevens, Merton H. (7)
**Stevenson, G. McKay (20)**
Stevenson, George S. (13)
Stewart, Edwin F. (13)
Stewart, Irving J. (8)
Stewart, Katherine E. (19)
Stewart, Robert G. (7)
**Stewart, Sloan G. (1)**
Stewart, Walter B. (1)
Stickles, Lloyd C. (7)
Stiles, C. Campbell (7)
Stockfisch, Robert H. (9)
**Stoddard, Gordon V. (7)**
Stokes, Anthony T. (9)
Stokes, Donald E. (7)
Stokes, Earle B. (7)
Stokes, Joseph (3)
Stokes, S. Emlen (3)
Stoll, George F. (7)
Stolow, Alan A. J. (10)
Stoltz, Raymond R. (16)
Stone, Frank P. (4)
Stone, Russell B. (21)
Storaci, Frank S. (11)
**Stouter, Francis L. (16)**
Strack, Jerome A. (7)
Strack, Vincent J. (7)
Strahan, Frank G. (13)
Strasser, Hans A. (7)
Straub, Herbert H. (7)
Straughn, Clinton C. (13)
Straus, Max (7)
Strauss, Arthur (13)
**Strauss, Clifton J. (20)**
**Strauss, Frederick (7)**
Strauss, Max (7)
Strauss, William T., Jr. (7)
Streen, Morris E. (7)
Street, Daniel B. (9)
**Strelinger, Alexander (20)**
Strenski, John (3)
Strom, Abraham (20)
Strong, Alonzo P. (7)
Stuart, Alexander A. S. (5)

Stuart, J. Earle (20)
Stuart, William C. (9)
Sturchio, Edoardo (7)
Sturchio, Eugenio (7)
**Stybel, Joseph (20)**
**Subin, Harry (1)**
Sucoff, Moses C. (16)
Suesserman, Henry (7)
**Suffness, Gustave (20)**
**Sufrin, Emanuel (4)**
Sullivan, Charles J. (12)
Sullivan, James A. (9)
**Sullivan, John B. (2)**
Sullivan, William M., Jr. (16)
**Sullivan, William T. (7)**
Sulouff, S. Henry (9)
Summerill, Garnett (4)
Summers, Alfred D. (11)
Summey, Thomas J. (3)
Surgent, George W. (16)
**Sussman, Harold (9)**
Suter, Harry F. (17)
**Sutherland, William W. (16)**
**Sutnick, Theodore B. (11)**
**Sutton, Harold L. (7)**
Sutton, Joseph G. (7)
Swain, Richard D., Jr. (7)
Swern, Nathan (11)
Swertfeger, Herbert W. (11)
**Swiecicki, Martin E. (4)**
Swiney, Juliana C. (9)
Swiney, Merrill A. (9)
**Symes, Earl R. (7)**
Szerlip, Leopold (7)
Szivos, Louis A. (7)
**Szold, Norman F. (15)**
Szuch, Nicholas (12)
Szymanski, John J. (16)

ASSOCIATE MEMBERS

Saco, Louis S. (16)
**Saseen, Charles A. (1)**
**Scovern, Louis (16)**
Seaton, Stuart P. (11)
Starr, George R., Jr. (7)
Stein, Harriet N. (16)
Straus, Walter (11)

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# T

ACTIVE MEMBERS

**Taber, Frederick S. (12)**
Taber, Leslie R. (16)
Taff, Harry (7)
**Taffet, William (7)**
**Taft, Herman L. (9)**
**Talmage, William G. (14)**
Talty, Francis (9)
Talty, John C. (9)
**Tansey, W. Austin, Jr. (7)**
**Taranto, Michael (20)**
Tarbell, Harold A. (7)
Tataryan, Hovsep (9)
**Tatem, Henry R., Jr. (4)**
Tator, Arthur E. (20)
**Taylor, Malcolm C. (14)**
**Taylor, Raymond A. (15)**
Teeter, Charles E. (7)
**Teichholz, Max H. (16)**
**Tell, M. Edward (16)**
Teller, Daniel W., Jr. (14)
**Temes, J. Howard (9)**
Tenney, Albert S. (7)
**Tenney, Luman H. (11)**
Tennis, Edgar M. (2)
Tepper, Victor (7)
**terKuile, Reinold W. (2)**
**Terrell, Edward E. (20)**
**Terreri, D. Joseph (14)**
Terwedow, Walter G. (9)
Teskey, Stanley (14)
Tether, Russell K. (2)
Thalheimer, Edward J. (6)
Thomas, Claude W. (17)
Thomas, George N. (6)
Thomas, Harry G. (13)
**Thomas, Irene O. (16)**
**Thomas, John H. (7)**
**Thomas, Leon H. S. (16)**
Thomas, Ralph B. (9)
Thomas, Thomas S., Jr. (14)
Thomison, Harry E. (7)
Thompson, Arthur F. (7)
Thompson, Austin B. (7)
**Thompson, Edward C. (16)**
Thompson, Minturn R. (20)
Thompson, Penrose H. (4)
Thomson, Carroll S. (7)
Thorne, Nathan (3)
Thorne, William P. (16)
Thornhill, Arthur C. (7)
**Thornley, William F. (7)**
**Thornton, P. John S. (18)**
**Thron, Leopold E. (16)**
Tidaback, John D. (20)
Tidwell, Harold F. (9)
**Tilles, Samuel (15)**
Tillis, Herman H. (7)
Tilton, William R. (7)
**Timberlake, Baxter H. (1)**
**Tirrell, C. Malcolm (7)**
Tisch, Leon (12)
Toal, Joseph (2)
Tobey, Franklin J. (7)
**Tobey, John R. (7)**
Toczek, Heinrich A. (7)
Todd, Francis H. (16)
**Tolomeo, Martin E. (18)**
Tolor, Stanley (20)
Tomaluoli, Michele (9)
**Tomec, Otto C. (11)**
**Tomec, Richard F. (7)**
Tomkins, William (16)
**Tomlins, Francis I. (2)**
Tomlinson, Rolland D. (20)
Tompkins, Grenelle B. (10)
**Torppey, John J. (7)**
Toscano, George A. (2)
**Toth, Elmer F. (9)**
Towbin, Adolph (15)
Townsend, John B. (5)
Townsend, Leslie M. (20)
**Toy, Calvert R. (12)**
Tracy, George T. (3)
**Traganza, Robert W. (4)**
Trano, Giovanni (20)
Trautwein, Charles F. (7)
Treiber, Benjamin A. (11)
Tretter, Hans L. (11)
**Triarsi, Anthony J. (20)**
Trippe, Clarence M. (13)
**Trippe, Morton F. (13)**
Troedsson, Bror S. (7)
**Tucker, Sidney (12)**
**Tuly, Ralph (7)**
Tunis, Benno B. (7)
Turi, Amedeo E. (7)
Turner, Charles F. (7)
Turner, Isabel B. (2)
Tushnet, Leonard (7)
**Tutela, Arthur C. (7)**
Tutschulte, Ernest (7)
Tweddel, George K. (16)
**Twinem, Francis P. (2)**
Twitchell, Adelbert B. (7)
Tymeson, Walter R. (7)
Tyndall, Alice E. (20)
Tyndall, Hugh H. (9)
Tyndall, Martha W. (20)
Tyson, Frances B. (2)

ASSOCIATE MEMBER

**Tarta, Ciro S. (16)**

# U

ACTIVE MEMBERS

Udinsky, Hyman J. (16)
Uhr, Jacques S. (12)
Ulan, Jerome (12)
Ulan, Oscar (7)
Ulmer, Chester I. (8)
Ulmer, D. H. Bartine (3)
**Ulvestad, Lawrence E. (7)**
Underwood, J. Harris (8)
Upham, Helen F. (13)
Urbach, George (7)
Urbaniak, Henry S. (11)
Urbanski, Matthew F. (12)
Urevitz, Abraham (9)
**Utens, Max (2)**
**Utkewicz, Edmond A. (9)**
Uzzell, Edward F. (1)

ASSOCIATE MEMBER

**Usher, Glenn S. (11)**

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# V

ACTIVE MEMBERS

Vaczi, Stephen (11)
Valentin, Irmgard (7)
Vallario, Frank A. (7)
**Vanderbeck, James J. (16)**
Vanderbeek, Andrew B. (16)
**Vanderbeek, Frank B. (16)**
Vanderbeek, Stuart W. (2)
Vander Clock, Cornelius (16)
Vander Veer, H. Garrett (7)
Van Dyke, Joseph S. (2)
Van Eerde, Albert (16)
Van Emburgh, George H. (7)
**Van Gieson, Edward J. (7)**
**Vann, Felix H. (2)**
Vannatta, George W. (7)
Vanneman, Joseph S. (11)
Van Ness, H. Roy (7)
**Van Riper, William D. (2)**
Van Schott, Gerard J., Jr. (16)
**Van Sickle, Albert W. (14)**
**Van Winkle, Charles I. (2)**
Van Winkle, John S. (16)
Vargyas, Joseph C. (12)
Varney, William H. (21)
**Varriano, John L. (9)**
**Vento, Sebastian J. (11)**
**Venturo, Ralph C. (8)**
Verbeck, George B. (7)
Verdon, Robert E. (2)
Vermes, Leslie (19)
Vermeulen, Abram (16)
Vernaglia, Anthony P. (16)
Vilardo, Ross (2)
Villanova, Ralph N. (7)
Villapiano, Joseph G. (13)
**Vincent, Nicholas F. (7)**
Vinciguerra, Michael (20)
**Virgilio, Anthony A. (7)**
**Visceglia, Frank R. (16)**
Visconti, Joseph A. (9)
**Vita, Frank J. (2)**
Vitale, Dominic V. (20)
**Viteri, Luis E. (3)**
**Vitolo, Ralph E. (20)**
Vogel, H. Austin (20)
**Volpe, Donald J. (1)**
Vol-Tretter, Marta (11)
von Deilen, Henry O. (14)
Von Hofe, Frederick H. (7)
Von Oehsen, William H. (13)
Voorhees, Florence E. (7)
Voorhies, William S., Jr. (14)
Voorhis, Charles F. (3)
Vosburgh, Fred (16)
**Voss, J. Landon (14)**
Voss, John C. (3)
Vostrosablin, Nicholas A. (9)
Vreeland, Ralph J. (16)
Vroom, William L. (2)

ASSOCIATE MEMBERS

Vandenberg, Werner (1)
**Van Mater, John S. (12)**

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# W

ACTIVE MEMBERS

**Wacker, William F. (20)**
Wade, Francis A. (14)
Wade, Simon F. (20)
Wagner, J. George (3)
Wagner, John (7)
Wagner, Otto (20)
**Wagner, Richard (20)**
**Wainright, Melvin A. R. (13)**
Wakeley, William E. (7)
**Waldron, Edward L. (11)**
**Waldron, Robert E. (7)**
Walkenberg, Michael (7)
Walker, Ada H. (6)
**Walker, Harold G. (16)**
Walker, H. Burton (6)
**Walker, Levi M. (1)**
Walker, Robert B. (12)
Wallace, Marc J. (16)
**Wallach, Bernard (18)**
Wallack, Charles A. (7)
**Wallack, Eli A. (9)**
Wallhauser, Henry J. F. (7)
Walscheid, Arthur J. (9)
Walsh, Charles R. (7)
Walsh, Ronald J. (20)
**Walsh, Thomas J. (11)**
Walsh, Thomas J. (20)
Walters, George M. (12)
Walton, Gordon G. (16)
Walton, Ralph W. (7)
Wambsganss, Magdalena (7)
Wandall, Frederick G. (8)
**Wangner, William F. (7)**
Wantoch, Joseph (12)
**Warburton, Jack C. (16)**
Ward, Albert H. (16)
Ward, Albert J. (14)
Ward, Elisabeth B. (7)
Ward, Gertrude P. (7)
Ward, Leo J. (20)
Ward, Mary (2)
Ward, William R. (7)
**Ward, William R., Jr. (7)**
Ware, Carl N. (6)
**Warner, Halsey F. (7)**
Warner, William H. A. (7)
Warren, Charles B. (2)
Warren, David E. (16)
Warren, Earl L. (16)
Warren, Jacob (16)
Warter, Peter J. (11)
**Warwick, Ralph A. (4)**
Washburn, Philip C. (14)
Washington, William H. (7)
Wassing, Hans (16)
**Waterman, Samuel M. (7)**
Waters, Charles H. (11)
Waters, Edward G. (9)
Watkins, George R. (4)
Watman, Anthony J. (9)

**Watov, Samuel E. (11)**
Watson, Frederick S. (11)
Watts, Wilbur (11)
**Waugh, Bascom S. (4)**
**Way, Clarence W. (5)**
**Wayman, Bernard R. (11)**
Webb, Eleanor A. (20)
Webb, Wilson D. (2)
Weber, Francis C. (7)
Weber, John F. (12)
**Weber, Laura E. (9)**
Weber, Walter D. (9)
**Weeks, Belford A. (1)**
Weeks, Norman E. (7)
Weems, Don B. (8)
Wegryn, Louis S. (20)
Weigel, Edgar W. (20)
Weigel, Elmer P. (20)
Weigele, Carl E. (9)
Weimann, Max L. (4)
Weiner, Henry T. (12)
Weiner, Samuel E. (1)
Weinert, Henry V. (16)
Weinmann, Max H. (7)
Weinstein, Francis S. (7)
Weinstein, Leopold (7)
Weinstein, Morris W. (7)
Weinstein, Robert A. (19)
**Weinstock, Michael B. (7)**
Weintraub, William L. (16)
Weiser, Edward H. (19)
**Weisman, Stephen L. (16)**
**Weiss, Abram (9)**
Weiss, Herman (14)
Weiss, Louis (7)
Weiss, Morris J. (9)
**Weiss, Mortimer H. (7)**
Weiss, Selma (7)
**Weissberg, William W. (20)**
Weissman, Meyer T. (20)
**Welkind, Allen A. (7)**
Weller, Arthur (7)
**Wells, William C. V. (3)**
**Weltchek, Herbert (20)**
**Wentzell, J. Earl (8)**
**Wesson, Harrison R. (7)**
**West, David H. (4)**
West, Edgar L. (11)
West, Gordon F. (4)
West, Guernsey F. (21)
West, Heston R. (21)
**Westerhoff, Peter D. (16)**
**Western, Frederic B. (20)**
Westney, F. Rolfe (1)
Weston, Clifford G. (7)
**Wethers, William A. (16)**
Wetterberg, Louis F. (12)
Whaland, Berta (6)
Whalen, Edward C. (4)
Wheatland, Marcus F., Jr. (4)
Wheeler, James A. V. (9)
**Wheeler, William K. (7)**
Whelan, Edward P. (7)
**Whims, Clarence B. (1)**
**Whinery, Joseph F. (20)**
**Whitaker, Henry J. (8)**
**White, Frank S. (2)**
White, Harry J. (12)
White, Hugh M. (9)
White, R. Rostin (1)
**White, Richard E. (16)**
White, Robert R. (7)
**White, Thomas J. (9)**
Whiticar, John H. (5)
Whitken, Albert I. (20)
Whitman, Lloyd B. (2)
Whittaker, Neil M. (2)
Wiant, Herman E. (4)
Wichman, Heins (9)
**Widetsky, Alfred (2)**
Wiener, David (7)
**Wiesenfeld, Benjamin (12)**
Wiesler, Howard M. (11)
Wiggins, Ulysses S. (4)
**Wikoff, John L. (11)**
Wilbur, Franklin L. (13)
**Wilcox, Frank A. (9)**
Wilentz, William C. (12)
**Wilkins, Stanley O. (13)**
Willan, Edward H. (7)
Willey, F. Parker (7)
**Williams, David P. (14)**
Williams, Edith B. (2)
Williams, Frank A. (20)
Williams, Harry D. (11)
Williams, Hiram (16)
Williams, John J. (7)
**Williams, Leonard D. (20)**
Williams, Louis E. (14)
**Williams, Manley C. (20)**
Williams, William C. (2)
Williams, William C. (4)
Willis, Benedict P. (2)
Willner, Irving (7)
**Willner, Philip (7)**
Willson, James H. (7)
Wilner, Arthur S. (11)
**Wilner, Irving (11)**
Wilson, Charles W. (6)
Wilson, Harrison B. (2)
Wilson, Herbert H. (6)
Wilson, Isam E. (4)
**Wilson, John H., Jr. (7)**
Wilson, Lawrence A. (1)
**Wilson, Lester R. (4)**
Wilson, Robert B. (13)
**Winn, Samuel L. (1)**
Winslow, John H. (6)
Winter, Carl M. (4)
Winter, Egon W. (7)
Winter, Gladys C. (2)
Winters, Walter M. (16)
Wishnack, Meyer (16)
Witkoff, Ben. (2)
Witmer, John D. (12)
Witte, C. Norman (15)
Wittenborn, William F. J. (11)
Woelfle, Henry E. (9)
**Wolbert, Charles M. (9)**
Wolf, Erich (16)
Wolf, Frank A. (21)
Wolf, Israel J. (16)
Wolf, Raymond E. (7)
**Wolfe, Edward E. (2)**
Wolfe, Jacob S. (7)
Wolfe, William W. (7)
**Wolff, Herbert M. (11)**
Wolff, Jerome M. (20)
**Wolfram, Julius (18)**
**Wolfson, Harry (16)**
Wolgin, Philip L. (20)
**Wolowitz, Harry B. (2)**
Woltz, Sidney (9)
**Wood, E. LeRoy (7)**
Wood, Oran A. (8)
**Woodman, Charles B. (14)**
Woodruff, Dare (6)
Woodruff, Ralph G. (13)
Woodruff, Stanley R. (9)
Woody, McIver (20)
Woolf, Bernhardt H. (7)
Worcester, George F. (2)
Work, John L. (7)
**Woronoff, Murray (13)**
Wort, Frederick J. (7)
Worthington, Joseph A. (13)
Wrensch, Alexander E. (7)
**Wright, Herman W. (8)**
Wright, Ralph S. (4)
Wright, Robert E. (7)
Wroblewski, Benjamin M. (4)
Wry, Dean A. (16)
Wry, Orlin V. (2)
Wuerthele, Virginia E. (7)
Wuester, William O. (20)
**Wujciak, Henry J. (7)**
Wurts, Margaret M. (7)
**Wurzel, Milton (7)**
Wyatt, Joseph H. (7)
Wyker, Arthur W. (7)
**Wyman, Edward H. (3)**
Wynder, Alfred (7)

ASSOCIATE MEMBERS

**Wagener, William L. (1)**
Walker, Otto (12)
Williams, Henry N. (12)

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# Y

ACTIVE MEMBERS

Yablonsky, Max (7)
**Yachnin, Samuel C. (16)**
Yadkowsky, Emanuel (7)
**Yaeger, Leslie A. (11)**
**Yager, J. Allen (16)**
Yagol, Benjamin (20)
**Yaguda, Asher (7)**
**Yankowiez, Michael (7)**
Yanowitz, Bernard (9)
Yates, Glen L. (7)
Yates, John S. (16)
Yeaton, William L., Jr. (9)
Yeaw, Ralph C. (16)
**Yelin, Gabriel (7)**
**Yellin, Charles H. (20)**

Yolken, Harry (16)
**Yontef, Reuben (9)**
**York, James L. (2)**
York, Wilbur H. (11)
**Yorke, Edward T. (20)**
**Yoskalka, Jack S. (7)**
Young, Franklin C. (20)
Young, George J. (14)
Young, I. Henry (7)
Young, James L. (18)
Young, John H. (7)
Young, Ralph A. (20)
**Yuckman, Robert O. (20)**
**Yuckman, William (20)**
**Yudkoff, William (9)**
**Yunck, William P., Jr. (9)**

ASSOCIATE MEMBERS

**Yoskowitz, Benjamin (16)**

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# Z

ACTIVE MEMBERS

**Zacchino, Arnold A. (2)**
Zacher, Andrew A. (7)
**Zager, Saul (7)**
Zalewski, Irene J. (16)
Zapf, Reville D. (8)
Zappala, John (17)
Zbar, Joseph E. (9)
Zehnder, A. Charles (7)
**Ziccardi, Anthony V. (3)**
Zick, Clara U. (16)
**Zimmer, William (7)**
**Zimmerman, Coler (7)**
Zimmerman, Robert F. (14)
Zimskind, Joshua N. (11)
**Zingales, Joseph A. (20)**
**Zingali, John A. (7)**
Zitani, Alfred M. (9)
Zuck, Arthur C. (21)
Zuck, John A. (14)
Zuckerman, David E. (16)
Zvaifler, Nathan (7)
**Zweibel, Leonard (7)**
Zweigel, Isidore (7)
Zybulewski, Edmund A. **(7)**

# MEMBERSHIP OF COUNTY MEDICAL SOCIETIES

Comprising

## THE MEDICAL SOCIETY OF NEW JERSEY

## ON MARCH 1, 1945

**Bold face type indicates members in service**

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## ATLANTIC COUNTY (1)

Society organized June 7, 1880. Meets second Friday evening monthly, except in June, July and August. Annual Meeting in May.

### ACTIVE MEMBERS

Allman, David B., 104 St. Charles pl., Atlantic City
Andrews, Clarence L., 1616 Pacific av., AtlanticC'y
Axilrod, Maurice H., 2620 Pacific av., Atlantic C'y
Barbash, Samuel, 1902 Pacific av., Atlantic City
Bartlett, Clara K., 4301 Atlantic av., Atlantic City
Bassett, Norman H., 1616 Pacific av., Atlantic C'y
Beir, Ily R., 3900 Atlantic av., Atlantic City
**Bew, Richard C., Navy**
Boysen, Theo. H., 807 White HorsePk.,EggHarb'r
Bradley, Robt. A., 1616 Pacific av., Atlantic City
Brown, J. Carlisle, 101 S. Indiana av., Atlantic C'y
**Carrington, William J., Army**
**Chalfant, W. Paxson, Jr., Army**
Charlton, C. Coulter, 124 S. Illinois av., Atl. City
Clark, S. Worth, 152 S. No. Carolina av., Atl. C'y
Cleary, Joseph P., Minotola
Corson, Filbert R., 101 S. Indiana av., Atlantic C'y
Crane, Bernard, 306 Pacific av., Atlantic City
Dalton, S. Eugene, 101 S. Surrey av., Ventnor
Davidson, Harold S., 101 S. Indiana av., Atl. City
deHellebranth, Roland T., 104 S. Fr'nkf't av.,Ventn'r
**DiNicolantonio, Vincent J., Army**
**Diskan, Samuel M., Army**
**Donnelly, William A., Navy**
**Durham, Robert B., Navy**
Durham, Royal E., 100 S. New Haven av., Ventnor
**Dyer, Edward H., Army**
Eckert, Walter L., 809 Stenton pl., Ocean City
**Elliott, Frazier J., Army**
**Erber, Leonard B., Army**
Ernst, Philip A., 16 E. Main st., Mays Landing
Esposito, Antonio L., 31 12th st., Hammonton
Ewens, Arthur E., 3600 Pacific av., Atlantic City
Fish, Clyde M., 7 W. Washington av., Pleasantville
Fox, Wm. W., 101 S. Indiana av., Atlantic City
Frank, Myrtile, 227 Philadelphia av., Egg Harbor
**Frank, Perry, Navy**
**Goldstein, Samuel, Army**
Gordon, Benjamin L., 1616 Pacific av., AtlanticC'y
Gordon, Maurice B., 6917 Atlantic av., Ventnor
Gorson, Samuel F., 2005 Pacific av., Atlantic City
**Gottlieb, Morris, Army**
Grier, Robt. M., 50 E. Washington av.,Pl'santville
Gross, Max, 7401 Atlantic av., Margate City
**Gruhler, Jean A., Army**
Guion, Edward, Atlantic Co. Hosp., Northfield
**Halpern, Samuel, Army**
**Harris, William O., Army**
**Hersohn, Wm. W., Army**
Hess, L. Elmore, 19 E. Bolton av., Absecon
Hoffman, Harry S., 3302 Pacific av., Atlantic City
Holmes, H. David, 15 N. Indiana av., Atlantic C'y
**Holoman, M. Browne, Army**
Holt, Edward Z., 4100 Atlantic av., Atlantic City
**Hudson, Howard S., Army**
Hyman, Charles, 2807 Pacific av., Atlantic City
**Infield, Gerald L., Army**
Irvin, John S., 1910 Pacific av., Atlantic City
Jacobson, J. Joseph, 1616 Pacific av., Atlantic C'y
Johnson, V. Earl, 101 S. Indiana av., Atlantic City
Kahn, Leo, 32 States av., Atlantic City
Kaighn, Chas. B., 101 S. Indiana av., Atlantic City
**Kline, Herman, Army**
Konzelmann, Frank W., 304 S. Shore rd, Absecon
Krechmer, Abraham, 400 Pacific av., Atlantic City
Lawther, Boyd M., 1401 Shore rd., Northfield
Leonard, Isaac E., 2842 Atlantic av., Atlantic City
**Leonard, Isaac E., Jr., Army**
**Magill, Marcus, Army**
**Major, Morton M., Army**
Marshall, H. Donald, 707 N. Indiana av., Atl. City
**Marvel, Peter H., Army**
Mason, James R., 1616 Pacific av., Atlantic City
McGeehan, Stanley M., 6505 Atlantic av., Ventnor
Merendino, Anthony G., 2720 Pacific av., Atl. City
MeVay, James C. F., 2907 Pacific av., AtlanticC'y
Milano, Cesare A., 1 S. Brighton av., Atlantic City
**Mishler, Jay E., Army**
**Molitch, Matthew, Army**
**Murray, Clifford K., Navy**
**Nickman, E. Harrison, Army**
**Oesterlin, Ernst J., Army**
Pennington, John, 101 S. Indiana av., Atlantic C'y
Perez, John F., 2518 Arctic av., Atlantic City
Pilkington, Albert, 117 S. Virginia av., AtlanticC'y
Poland, Geo. A., 206 E. Verona av., Pleasantville
Quinn, Norman J., 3303 Pacific av., Atlantic City
**Read, Hilton S., Army**
Repici, Anthony J., 107 N. 3rd st., Hammonton
Reyner, Daniel C., 2703 Pacific av., Atlantic City
**Rieck, Allan, Army**
**Rise, Wilson S., Army**
Roop, William O., 101 S. Indiana av., Atlantic C'y
**Rosenberg, Louis, Army**
Rosenblatt, Sidney, 1904 Pacific av., Atlantic City
**Rubba, Russell R., Army**
Salasin, Samuel L., 511 Pacific av., Atlantic City
Scanlan, D. Ward, 15 S. Illinois av., Atlantic City
Schwarzkopf, Geo. C., 2901 Pacific av., AtlanticC'y
Schwinn, Chas., 7600 Winchester av.,Margate City
**Shavelson, Irving C., Army**
Shenfeld, Isaac, 4806 Atlantic av., Ventnor
Shivers, Chas. H. deT., 121 S. Illinois av., Atl. City
**Shuster, Samuel A., Army**
Silvers, Homer I., 16 S. Suffolk av., Ventnor
Sinkinson, Chas. D., Jr., 1616 Pacific av., Atl. City
Smith, Andrew M., 344 Philadelphia av.,EggH'rb'r
**Stamps, G. Ruffin, Army**
**Stewart, Sloan G., Army**
Stewart, Walter B., 8 N. Tallahassee av., Atl. City

**Subin, Harry, Army**
**Timberlake, Baxter H., Army**
Uzzell, Edward F., 2703 Pacific av., Atlantic City
**Volpe, Donald J., Navy**
**Walker, Levi M., Army**
**Weeks, Belford A., Army**
Weiner, Samuel E., 904 Pacific av., Atlantic City
Westney, F. Rolfe, 1920 Pacific av., Atlantic City
**Whims, Clarence B., Army**
White, R. Rostin, 644 Shore rd., Somers Point
Wilson, Lawrence A., 114 N. Shore rd., Absecon
**Winn, Samuel L., Army**

**Number of Active Members and basis of representation, 122.**

### ASSOCIATE MEMBERS

**McCracken, Josiah C., Jr., Army**
McGahn, Joseph, 218 N. California av., Atl. City
Saseen, Charles A., Army
Vandenberg, Werner, 4116 Ventnor av., Ventnor
**Wagener, William L., Army**

### COURTESY MEMBERS

Rechtman, A. M., Atlantic City
**Starkes, Carlton C., Army**

### TRANSFERS

Konzelmann, Frank W., from Pennsylvania
Levine, Morris J., to Florida

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## BERGEN COUNTY (2)

Society organized February 28, 1854. Meets on second Tuesday of each month, except July and August. Annual Meeting in May.

### ACTIVE MEMBERS

Abbate, Charles C., 32 Main st., Lodi
Agayoff, John D., 127 S. Washington av.,Bergenf'd
Alexander, Samuel, 12 S. Main st., Park Ridge
**Alexander, Stewart F., Army**
Anderson, Reuben M., 15 Anderson st., Hackens'k
**Angelillis, Paul, Army**
**Angioletti, Louis V., Army**
Appold, George D., 60 E. Church st., Bergenfield
Baketel, H. Sheridan, 155 VanWagenen av.,Jer.C'y
**Baldwin, John F., Army**
Balze, Henry R., 147 Christie st., Leonia
**Banta, Raymond E., Army**
Barbash, Roslyn H. W., 835 Red rd., Teaneck
**Barlow, G. Barton, Army**
Barnes, William J., 155 Engle st., Englewood
Baron, Herbert A., 150 Terrace av., Hasbr'k Hts.
Beres, Albert J., 492 Wood-Ridge av.,Wood-Ridge
Berke, Raynold N., 430 Union st., Hackensack
**Bernard, Richard C., Army**
**Beyer, William, Army**
Black, LeRoy W., 33 W. Passaic av., Rutherford
Blauvelt-Welles, Grace B.,76 Heights rd.,Ridgew'd
Bleasby, Charles B., 136 Passaic st., Garfield
**Blenkle, Victor A., Army**
Bono, Joseph J., 647 Anderson av., Cliffside Park
Bookstaver, Barnet S., 241 Cedar lane, Teaneck
Bosch, Taeke, 290 E. Franklin Turnpike, Hohokus
**Branon, Mark E., Army**
Braun, Joseph C., 531 Broad av., Palisades Park
Bregman, Alexander, 2 Dempsey av., Edgewater
Brennan, Alfred T. V., Jr., 275 Engle st., Englew'd
**Brown, John L., Army**
**Brown, Leonard, Army**
**Brozyna, Mieczyslaw, Army**
Buckley, Paul J., 159 Palisade av., Bogota
**Bump, Samuel C., Army**
Burnham, Lyman, 229 Engle st., Englewood
Burns, Geoffrey C. H., County rd., Demarest
Busicco, Philip S., 131 Liberty rd., Englewood
Campbell, James M., 101 S. Central av., Ramsey
**Candio, Vincent P., Army**
**Carbone, Ralph, Army**
**Carroll, Thomas R., Navy**
Cartnick, Louis C., 228 Hillcrest av., Wood-Ridge
**Caruso, Paul F., Army**
**Casciano, Adolph D., Army**
Catania, Joseph P., 140 Passaic st., Garfield
Chase, Kalman, Jr., 80 Sheridan av., Hohokus
Christensen, Osborne D., 315 Terrace av.,Hsbk.Ht.
**Clarie, D'Arcy C., Army**
Clarke, Edward W., 435 Warwick av.,W.Englew'd
Cloud, Albert W., 139 Hugenot av., Englewood
Connor, Clarence A., 1586 Center av., Fort Lee
Cooper, Howard M., 37 Ridge rd., Rutherford
**Coppoletta, Joseph M., Navy**
Corn, David, 119 Park st., Ridgefield Park
**Coughlin, Joseph J., Army**
Crandall, John K., 200 Main st., Fort Lee
Cropsey, Chas. D., 168 Chestnut st., Rutherford
**Cuono, Joseph D., Army**
**Curtis, Donald A., Army**
D'Agostin, Henry, 243 Fulton ter., Cliffside Park
**Daly, John F., Army**
**D'Amato, Charles R., Army**
Dayton, Spencer T., 86 W. Demarest av., Englew'd
**DeBiaso, Cornelius V., Army**
Decker, John G., 216 Blvd., Hasbrouck Heights
Demarest, J. Willis, 124 State st., Hackensack
Denig, Ralph D., 370 State st., Hackensack
**Denison, Ward C., Navy**
DeSanto, A. M., Summit av. & Essex st.,Hack'ns'k
**Deuell, William D., Navy**
Dezer, Chas. N., Jr., 210 Main st., Hackensack
Dickson, John D., 202 Larch av., Bogota
Dilger, Frederick G., 210 Main st., Hackensack
**Doyle, George F., Army**
**Duisberg, Richard E. H., Army**
**Edgerly, Sherburn E., Navy**
Edwards, J. Bennett, 144 Woodridge pl., Leonia
Ehrlich-Morrow, Laura E., 65 L'vgst'n av.,L'dh'st
Ellmers, Basil J., 304 Milford av., New Milford
Essertier, Edward P., 275 State st., Hackensack
Essertier, Harland C., 263 Franklin av., Ridgew'd
**Evans, J. Lawrence, Jr., Army**
Farmer, Vincent, 430 Union st., Hackensack
**Farr, Walter J., Army**

Fermaglich, Harry B., 881 Garrison av., Teaneck
Ferrari, Andrew F., 196 Main st., E. Rutherford
Fessler, William, 31 Knox av., Cliffside
**Fietti, Vincent G., Army**
Finke, George W., 237 State st., Hackensack
Finke, John H. D., 19 Hudson st., Hackensack
Fisher, Percy C., 145 Franklin av., Ridgewood
**Fitzhugh, William F., Army**
**Fitzpatrick, Leo J., Army**
Fliegel, Wm. M., 85 W. Passaic st., Maywood
Forte, F. Chester, 111 State st., Hackensack
Freeland, Frank, 281 State st., Hackensack
**Friedman, Abraham I., Army**
Galotta, Margaret L., 533 Prospect av., Hack'ns'k
**Gatti, Joseph D., Army**
**Gershman, Joseph G., Navy**
Gilady, Raphael, 205 Union st., Hackensack
Giordano, Wm. C., 855 Broad av., Ridgefield
Gittelsohn, Isador, 700 Kind'rkam'k rd.,RiverEdge
**Gitterman, David A., Army**
**Gladstone, Albert L., Army**
Goldberg, David, Westwood av., Westwood
**Goldfarb, Abraham, Navy**
Gordon, Sarah, 327 Cedar lane, Teaneck
**Gould, Werner, Army**
Gramsch, A. Louis, Bergen Pines, Oradell
Greenfield, Arthur W., 50 Anderson st.,Hackens'k
Greenfield, Wm. J., 50 Anderson st., Hackensack
**Grimes, Robert R., Army**
Groff, Parker A., 159 Washington av., Little Ferry
**Grueninger, Edward F., Army**
Hagovsky, Albert J., 301 Hackens'k st., Carlstadt
Hallett, Frederick S., 200 Passaic st., Hackensack
Halpern, Herman, 143 Engle st., Englewood
**Halpern, Jesse O., Army**
Hardy, Grace C., 157 Engle st., Englewood
Harryman, Wm. K., 271 Union st., Hackensack
**Hawes, Vernon L., Army**
Helff, Joseph R., 1367 Teaneck rd., W. Englewood
**Heller, George, Army**
**Hensle, Otto S., Army**
**Hillsman, R. Bryan, Army**
**Hirsch, John J., Army**
**Hitzemann, Louis A., Navy**
**Horowitz, Herman J., Army**
**Hull, Donald B., Army**
Irwin, John H., 51 Tenafly rd., Englewood
Jacobitti, Edmund E., 491 Maywood av., Maywood
Jaslow, Seymour P., Wyckoff
Jenkins, Alvah R., 40 Armory st., Englewood
**Johnson, G. Leonard, Army**
**Johnston, Rufus O., Army**
**Johnston, Sidney F., Navy**
Jukofsky, Isidore D., 335 Main st., Ridgef'd Park
**Kakascik, Emil J., Navy**
Kastler, Franz, 54 Ames av., Rutherford
Keir, Floyd E., 308 Engle st., Englewood
Kennedy, Paul A., 147 Tenafly rd., Englewood
Kilts, Winfield S., 966 Garrison av., Teaneck
King, Chester A., 412 Kinderkamack rd., Oradell
Kingslow, George L., 346 1st st., Hackensack
**Kissinger, Donald J., Army**
**Klosterman, Julius A., Army**
Knapp, Richard E., 25 Hudson st., Hackensack
**Knight, William T., Army**
**Knowles, George M., Army**
Knox, Chas. A., 138 Bergen av., Ridgefield Park
Knox, Harriet L., 390 Union st., Hackensack
**Kosmlnsky, Louis, Army**
**Kraissl, Cornelius J., Army**
**La Barba, Peter J., Navy**
Lamberto, Vito A., 422 Stuyvesant av., Lyndhurst
Latona, Joseph A., 78 Main st., Lodi
**Legato, Samuel F., Army**
**Leummerz, Willard H., Army**
Lesko, Stephen W., 234 Mt.Pl'sant av.,E.Rutherf'd
Levitas, Geo. M., 199 Fairview av., Westwood
**Levitas, Irving M., Army**
Levy, Jack D., 191 Union st., Hackensack
Lewis, Alice B., E. Saddle River rd., Saddle River
**Liddy, Frank J., Army**
Littwin, Charles, 950 Queen Ann rd., Teaneck
Liva, Arcangelo, 100 Prospect av., Hackensack
**Liva, G. Albin, Army**
Liva, Paul F., 280 Stuyvesant av., Lyndhurst
**Loman, Samuel G., Army**
**Lombardi, Frank L., Navy**
**Lord, C. Donald, Army**
**Luria, Sanford A., Army**
**Lynch, Maurice M., Navy**
Lyons, Romola L. K.,171 Mead'wbr'k rd.,Englew'd
Macaulay, Francis A., 819 Elm av., Teaneck
MacKellar, James M., 26 E. Clinton av., Tenafly
**MacLaren, Philip J., Navy**
Maddren, Russell F., 372 Union st., Hackensack
**Mader, A. Ivan, Jr., Army**
Mahoney, Thomas H., 321 Ridge rd., Rutherford
**Maneene, Edward M., Army**
Mark, Harold I., 1022 Garrison av., Teaneck
Markley, Luther A., Holy Name Hosp., Teaneck
Marx, Fred'k J., 539 Kinderkamack rd.,RiverEdge
McCormack, Frank C., 95 Tenafly rd., Englewood
McFeely, Percy R., 242 Palisade av., Bogota
McGuire, Joseph T., 54 Main st., Lodi
McIlveen, Marion, 260 Godwin av., Ridgewood
**McLane, A. Donald, Army**
Mears, William G., 216 Hillside av., Leonia
**Megibow, Harold J., Army**
**Metz, Henry, Army**
Meyer, Howard M., 400 Maple Hill dr., Hackens'k
**Miller, Herbert G., Army**
Mockett, Walter W., 714 Palisade av., CliffsidePk.
**Modrys, Walter F., Army**
**Mores, Herbert R., Army**
Morrow, Joseph R., Bergen Pines, Oradell
Muller, Frederick L., 413 Third st., Carlstadt
**Mulligan, Luke A., Army**
**Myers, Norman V., Navy**
**Neary, Edward R., Army**
**Netz, Lester W., Army**
Neville, Robert J., 547 Main st., Hackensack
Nichols, Frank I., 52 Euclid av., Hackensack
Nicol, Lorenz C., 360 Larch av., Bogota
**Olpp, John L., Army**
Olson, Vendela E., 100 Prospect av., Hackensack
Oren, Hyman, 24 Park av., Park Ridge
**Padden, Aloysius F., Army**
Pagano, Peter, 324 Franklin av., Ridgewood
**Pallen, Conde deS., Army**
**Patti, Frank A., Navy**
Pedevill, Jos. R., 232 Highland av., Palisades P'k
Pellegrini, Vincent J.,315Rochelle av.,RochelleP'k
Perham, Roy G., 248 Blvd., Hasbrouck Heights
Pettit, Harry H., 138 Franklin av., Ridgewood
Phillips, Walter, 109 E. Palisade av., Englewood
**Pierce, Henry A., Army**
**Pindar, Arthur W., Army**
Pindar, Irene D., 627 Queen Anne rd., Teaneck
Pingitore, Eufelia, 30 Martin ter., Hackensack
Pitkin, Winifred, 170 S. Washington av.,Bergenf'd
**Pizzi, Peter J., Army**
**Policastro, Nelson C., Army**
Prall, Henry E., 755 Anderson av., Cliffside Park
**Prather, Charles G., Army**
Prather, John W., 155 Washington av., Dumont
**Protzman, Thomas B., Army**
Prout, Wm. B., 88 W. Forrest av., W. Englewood
Pullen, Guy F., 111 Leonia av., Leonia
Rader-Hoheb, Katherine, 5 Lincoln av., Rutherf'd
**Ravits, Everett C., Army**

Re, Natale M., 1003 Dearborn rd., Palisade
Reich, Samuel B., 286 Union st., Hackensack
Reinhold, H. E., 441 W. Englew'd av.,W.Englew'd
Richards, Ernest W., 374 DeWolf pl., Hackensack
Richardson, Charles A., Main st., Closter
**Ringe, Charles L., Jr., Army**
Ringewald, Robert H., 284 Broad av., Leonia
**Roberts, Charles D., Army**
Robinson, Silas E., Franklin T'rnpike, Waldwick
Romano, Anthony M., 332 Liberty av., Hillsdale
Rooks, Wendell H., Goffle Hill rd., Midland Park
**Ross, Selig J., Army**
Rowe, Joseph A., 174 S. Maple av., Ridgewood
**Roylance, F. Dean, Jr., Army**
**Rube, Joseph A., Army**
Rucker, William C., 408 Main st., Hackensack
Ryley, Harold W., 1 Lincoln pl., E. Rutherford
**Salmeri, Edward J., Army**
Salva, Edo J., 17 W. Central Blvd., Palisades P'k
Sandler, Moses, 2013 Center av., Fort Lee
**Sandler, Samuel A., Army**
Sarajian, Aram M., 131 Ayers ct., W. Englewood
Sarla, Michael, 55 Hudson st., Hackensack
Scerbo, Ernest, 1-09 34th st., Warren Point
**Schaberg, Frank J., Army**
Schiro, S. Robert, 73 Main st., Lodi
Schmidt, Walter W., 386 Palisade av., CliffsideP'k
Schretzmann, Rudolph C.,60D'n'lds'n av.,R'therf'd
Schultz, Irving A., 31-11 Broadway, Warren Point
**Scillicri, John, Army**
Scullion, Arthur A., 460 Anderson av., CliffsideP'k
Sealey, Henry J., 79 Washington av., Dumont
Segard, Christian P., 204 Glenwood av., Leonia
Seiler, Benjamin, 580 Palisade av., Cliffside Park
**Severud, Olaf J., Navy**
**Sexton, Edward V., Navy**
Seymour, Edward T., 55 Hillside av., Tenafly
Singer, Marie J. ,139 E. Madison av., Dumont
Skvarla, John A., 17 Koster st., Wallington
**Smaine, Enrique delC., Army**
Smith, Bryan A., 10 N. Monroe st., Ridgewood
Smith, Nehemiah E., 33½ Humphrey st.,Englew'd
**Snedecor, Spencer T., Army**
**Solworth, Lee, Army**
**Somers, Williard H., Army**
Sosnow, Louis M., 51 Central av., Hillsdale
**Spicola, Louis A., Army**
Spiegelglass, Abraham B., 417 Main st., Hack'ns'k
Spranz, William S., 546 Cradell av., Oradell
Stassi, Anthony V., 481 Passaic av., Lodi
**Sullivan, John B., Army**
Tennis, Edgar M., 375 Engle st., Englewood
**terKuile, Reinold W., Navy**
Tether, Russell K., Main st., Closter
Toal, Joseph, 803 Prospect av., Ridgefield
**Tomlins, Francis I., Army**
Toscano, George A., 305 Union st., Hackensack
Turner, Isabel B., 141 Sheffield av., Englewood
**Twinem, Francis P., Navy**
Tyson, Frances B., 101 Leonia av., Leonia
**Utens, Max, Army**
Vanderbeek, Stuart W., 143 Engle st., Englewood
Van Dyke, Jos. S., 42 Palisade Blvd., Palis'desP'k
**Vann, Felix H., Army**
**Van Riper, William D., Army**
**Van Winkle, Charles I., Navy**
Verdun, Robert E., 520 Westview av., Cliffside
Vilardo, Ross, 109 Marsellus pl., Garfield
**Vita, Frank J., Army**
Vroom, Wm. L., 88 W. Ridgewood av., Ridgewood
Ward, Mary, 30 Engle st., Tenafly
Warren, Chas. B., 181 Prospect av., Bergenfield
Webb, Wilson D., 316 State st., Hackensack
**White, Frank S., Navy**
Whitman, Lloyd B., 7 W. Clinton av., Bergenfield
Whittaker, Neil M., 418 Main st., Hackensack
**Widetsky, Alfred, Army**
Williams, Edith B., 70 Anderson st., Hackensack
Williams, William C., 9 Ridge rd., Rutherford
Willis, Benedict P., 185 Montross av., Rutherford
Wilson, Harrison B., 430 Union st., Hackensack
Winter, Gladys C., 717 Norma court, Teaneck
Witkoff, Ben., 215 Terrace av., Hasbrouck Heights
**Wolfe, Edward E., Army**
**Wolowitz, Harry B., Army**
Worcester, George F., 220 Engle st., Englewood
Wry, Orlin V., 95 High st., E. Rutherford
**York, James L., Army**
**Zacchino, Arnold A., Navy**

**Number of Active Members and basis of representation, 325.**

## ASSOCIATE MEMBERS

Buchholz, Alexander, 417 Main st., Hackensack
Burokus, William, 21 E. Pleasant av., Maywood
Clark, Margaret A., Glen rd., Woodcliff Lakes
Lowe, Louise, 125 Lawrence av., Hasbrouck Hts.
Pramuk, Clarence, 937 Lincoln av., Teaneck
Rappaport, Doris I., 1363 Sussex rd., W. Englew'd

## COURTESY MEMBERS

Franklin, Sidney I., Michigan
Hambright, Arthur M., Ramsey
Opitz, Russell B., Palisade
Pfeiffer, Alfred G., Paramus
Salter, Kent, Paterson
Spickers, William, Paterson

## HONORARY MEMBERS

Burbank, Hugh E., Lyndhurst
Clock, Ralph O., Scarsdale, N. Y.
Proctor, James W., Tenafly
Tidwell, George W., Rutherford

## TRANSFERS

Cochrane, Cleland D., to Florida
Tanner, Monroe J., to Ohio

## BURLINGTON COUNTY (3)

Society organized May 19, 1829. For the duration the Society meets (excepting June, July and August) second Thursday evening during October, December, February, April and May at Riverton Country Club, Riverton, N. J.; each second Thursday afternoon during September, November, January and March at 4:00 p. m. at the Burlington County Hospital, Mt. Holly.

### ACTIVE MEMBERS

**Anderson, Richard D., Navy**
Atkinson, James Q., 63 Mill st., Vincentown
Barton, Amy S., 509 Chester av., Morrestown
**Betts, R. Winfield, Army**
Bray, William E., 41 Elizabeth st., Pemberton
Busansky, Samuel T., Circle dr., Browns Mills
**Clement, John B., Army**
Conroy, John S., 124 E. Broad st., Burlington
Curtis, Howard C., 224 E. Main st., Moorestown
Darlington, Emlen P., New Lisbon
**Davis, E. Vernon, Army**
Davis, Jacob M., 1400 High st., Burlington
Dickson, T. Bruce, 408 Main st., Riverton
Downs, Roscius I., 430 Cooper st., Woodbury
Fahrenbruch, Fred'k D., 101 Garden st., Mt.Holly
Fischbach, Adolph D., 108 Hanover st.,Pemberton
Geary, Russell D., 337 Bridgeboro rd., Riverside
Gibson, Chas. F., 131 E. Federal st., Burlington
Haines, Edgar J., 45 S. Main st., Medford
**Haldeman, Robert E., Army**
Hale, Matthew J., 467 High st., Burlington
Hartman, Luther M., 111 E. Main st., Maple Shade
**Hebble, Howard M., Navy**
Hornberger, J. Howard, 4th & Main sts., Roebling
Hunter, Edward R., 321 Union av., Delanco
**Imhoff, Robert E., Army**
**Kuder, Joseph M., Army**
**Landis, Harry P., Jr., Army**
**LeFavor, Dean H., Army**
Longsdorf, Harold E., 200 Garden st., Mt. Holly
Love, Elizabeth F., 142 E. Oak av., Moorestown
Lucas, W. Fred, 23 W. Broad st., Burlington
Mark, Harry B., 600 Elm ter., Riverton
McDonnel, Gerald E., 470 High st., Mt. Holly
Mendenhall, Clinton D.,412 F'rnsw'th av.,B'rd'nt'n
Metzer, Emma P. W., 430 Fairview st., Riverside
**Metzer, Freeman W., Army**
**Meyer, Eugene A., Army**
Mills, Charles S., 106 Lippincott av., Riverton
**Muldoon, Edward J., Navy**
Munro, Charles A., Main st., Marlton
Newcomb, Marcus W., Browns Mills
**Newmeyer, Joseph, Army**
Peacock, Arthur B., 39 W. Main st., Columbus
Rachunis, Michael, Roebling
Remer, Daniel F., 417 High st., Mt. Holly
Rink, William E., 33 W. Union st., Burlington
**Rodman, E. Warren, Army**
Rogers, Harry L., 408 Main st., Riverton
**Sand, Abraham B., Army**
Schisler, Milton M., 2nd & Church sts., Florence
Scott, Parry M., 466 Cooper st., Beverly
Shapiro, Chas. S., S. Forklanding rd., MapleShade
Shipps, Hammell P., 739 Chestnut st., Delanco
**Siddall, John R., Army**
Small, E. Lester, 30 Branch st., Medford
**Sparks, Paul R., Army**
Stokes, Joseph, 220 E. Main st., Moorestown
Stokes, S. Emlen, 129 Chester av., Moorestown
Strenski, John, 540 Bridgeboro st., Riverside
Summey, Thos. J., 800 Golf View rd., Moorestown
Thorne, Nathan, 119 Chester av., Moorestown
Tracy, George T., 222 Warren st., Beverly
Ulmer, D. H. B., 199 Chestnut st., Moorestown
**Viteri, Luis E., Army**
Voorhis, Charles F., 330 Morgan av., Palmyra
Voss, John C., 634 Thomas av., Riverton
Wagner, J. George, Riverbank, Delanco
**Wells, William C. V., Navy**
**Wyman, Edward H., Navy**
**Ziccardi, Anthony V., Army**

**Number of Active Members and basis of representation, 71.**

### HONORARY MEMBER

Wilkinson, George H., Moorestown

### TRANSFERS

Barton, Amy S., from Texas

Rachunis, Michael, from Pennsylvania

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## CAMDEN COUNTY (4)

Society organized August 14, 1846. Meets first Tuesday in each month, October to May, inclusive, with an outing in June. Annual Meeting in May.

### ACTIVE MEMBERS

Anderson, Wm. M., 20 Kings H'way,W.,Hadd'nf'd
Andrus, David L., 805 Cooper st., Camden
**Asbell, Nathan, Coast Guard**
**Assante, M. Hugo, Army**
**Atlley, Kenneth L., Army**
**Baker, Banks S., Army**
Baker, Maurice E., 1149 Kaighn av., Camden
Barb, Kirk B., 1303 Princess av., Camden
**Barnshaw, Harold D., Navy**
**Barroway, James N., Army**
Becker, C. Frederick, 620 Benson st., Camden
Beideman, Casper M., 5 W. Maple av.,Merch'ntv'le
Bentley, David F., Jr., 406 Cooper st., Camden
**Betancourt, Raul R., Army**
**Bowen, Robert N., Army**
Braun, William, 406 Cooper st., Camden
Brennan, Chas. L. S., 14 S. Broadway, Gloucester
Brennan, John P., 429 Cooper st., Camden
**Brown, Stanley L., Navy**
Browning, Wm. J., 134 N. Centre st., Merchantv'le

**Burns, Wilmer F., Army**
Bush, Ralph K., 23 E. Maple av., Merchantville
Butler, Samuel S., 1100 Kaighn av., Camden
Carlander, Oswald R., 622 Cooper st., Camden
Casselman, Arthur J., 301 N. 2nd st., Camden
**Chesnick, Reuben B., Army**
Ciliberti, Frank J., Jr., 5th and Pine sts., Camden
Clark, Ernest W., 407 Cooper st., Camden
Clarke, R. Manning, 401 Wilson Bldg., Camden
**Cohen, Paul, Army**
Collier, Martin H., Camden Co. T.B.Hosp.,Lakel'n
Conlen, Richard, 514 Cooper st., Camden
**Cooper, Robert A., Army**
**Coxson, Harold P., Army**
**Crane, Reynold M., Navy**
Crowley, Joseph W., 4005 Westfield av., Camden
**Crist, Walter A., Navy**
**Cunningham, Joel B., Army**
**David, Leopold S., Army**
Davis, Albert B., 511 Cooper st., Camden
Davis, J. Stannard, 55 Kings Hwy., E., Haddonf'd
Decker, Henry B., 527 Penn st., Camden
Deibert, Irvin E., 538 Cooper st., Camden
**Del Duca, Vincent P., Army**
**Dempsey, J. Harvey, Army**
**Denbo, Elic A., Army**
**Di Ielsi, Anthony J., Army**
Donges, Clarence B., 442 Chambers av., Camden
**Driscoll, Charles D., Army**
**Drossner, Jacob L., Army**
**Ebner, Paul G., Army**
Ellis, Alexander, 513 Broadway, Camden
Ewing, Leslie H., 10 Broad st., Berlin
**Eynon, Harold K., Army**
**Eynon, James R., Army**
**Farrell, Edgar A. H., Army**
**Fessman, John W., Army**
Filkins, Cedric E., 418 Whitehorse Pike, Audubon
Fisher, Stella C., 4401 Westfield av., Camden
**Fridrich, Harry E., Army**
**Friedenberg, Sidney, Army**
Gamon, Robert S., 514 Cooper st., Camden
**Garrison, George H. H., Army**
Geissler, Elmer E., 327 Monmouth st., Gloucester
**German, George B., Army**
**Gilbert, Philip D., Army**
**Girardo, Anthony J., Army**
Glover, Lawrence L., 53 Kings Hy. W., Haddonf'd
Goldman, Samuel, 7th & State sts., Camden
Goldstein, Hyman I., 1425 Broadway, Camden
Gordon, Milton H., 12 N. 27th st., Camden
Gosper, Ralph W., 5719W'stf'd av.,Penns'kenTw'p.
**Grenhart, George W., Navy**
**Griffey, William C., Army**
Griscom, Lee E., 604 Broadway, Camden
Hadley, C. Frazer, 210 W. Maple av., Merchantv'le
Hadley, C. Frazer, Jr., 21 Haddon av., Westmont
Haines, Mabel C. S., 600 White HorsePk.,Audubon
Hallinger, Earl S., 517 Cooper st., Camden
Hanson, Alfred S., 539 Monmouth st., Gloucester
Haury, Victor G., 206 Cedarcroft av., Audubon
Hays, Roy G., 567 Haddon av., Collingswood
**Hemphill, Everett H., Army**
Hessert, Edmund C., 417 Cooper st., Camden
Hofer, William R., 125 Main st., Williamstown
Hollinshed, Beulah S., 600 Benson st., Camden
Horner-Rodger, Clara L., 937 Cooper st., Camden
Howard, J. Edgar, 67 Kings H'way, W., Had'nf'd
Hughes, Frank J., 429 Cooper st., Camden
Hughes, Thomas E., 223 Cooper st., Camden
Hummel, Ernest G., 414 Cooper st., Camden
**Hummel, Merwin L., Navy**
**Husted, Gerald W., Army**
Ironside, Paul A., 144 North dr., Haddonfield
Jack, H. Wesley, 538 Cooper st., Camden
Jackson, Charles H., 1250 Park Blvd., Camden
**Johnson, Herbert F., Navy**
Jones, John C., 805 Princeton av., Camden
**Judson, G. Vernon, Jr., Army**
Kain, Thomas M., 403 Cooper st., Camden
**Kerdasha, Richard F., Navy**
**Keyser, David, Army**
Kimler, William D., 312 Cattell av., W.Collingsw'd
Kinney, Albert G., 609 Clinton av., Haddonfield
Klarich, Philip, 702 Broadway, Camden
Kline, Cram R., 514 Cooper st., Camden
**Kraczyk, Michael J., Army**
**Kutner, Charles, Army**
Larossa, Ernest A., 561 Benson st., Camden
**Lee, Benjamin F., Navy**
Lee, Thomas B., 622 Cooper st., Camden
Lewis, Thomas K., 719 Cooper st., Camden
Locke, Henrik W., N.Y. ShipbuildingCorp.,Camd'n
Lovett, Joseph C., Municipal Hospital, Camden
MacAlpine, Kenneth B.,500 ChewsLdg.rd.,H'd'nf'd
**Magee, Edward S., Navy**
Magee, Russell S., 201 White Horse Pike,Audubon
Mahaffey, J. Lynn, 406 Warwick rd., Haddonfield
Maldeis, Albertos M. K., 117 N. 6th st., Camden
Manser, Ernest E., 309 Haddon av., Collingswood
Marcarian, Henry G., 917 Cooper st., Camden
Martin, William, 300 Westmont av., Haddonfield
McCallum, Arthur S., 213 Clements Br.rd.,Bar'gt'n
McCarthy, Arthur M., 2772 Federal st., Camden
McConaghy, Thomas P., 10th & Cooper sts.,C'md'n
**McDermott, Vincent T., Army**
**McGlade, Thomas H., Army**
McWilliams, Charles E., Church st., Blackwood
Mecray, Paul M., 405 Cooper st., Camden
**Mecray, Paul, Jr., Army**
Meyer, George P., 410 Haddon av., Camden
**Murray, Edwin N., Army**
Ondovchak, M. Frederic, KingsH'way,Mt.Ephraim
**Ornaf, I. Edward, Army**
**Osborn, Edward G., Army**
Phillips, Claude B., 891 Haddon av., Collingswood
Pike, Charles E., 4 E. Haddon av., Oaklyn
**Pinsky, Harry A., Army**
**Platt, Edward V., Army**
Pratt, Arthur G., 516 Cooper st., Camden
**Price, Henry S., Jr., Army**
Principato, Roberto, 402 Walnut st., Camden
Rapp, Robert F., 932 Haddon av., Collingswood
Read, Wm. T., Jr., Cooper Hospital, Camden
Rhone, David S., 1202 Haddon av., Camden
Richardson, Emma M., 581 Stevens st., Camden
**Riegert, Louis C., Army**
**Ristine, Edwin R., Army**
Roberts, Joseph E., Jr., 403 Cooper st., Camden
**Rudolph, John P., Army**
**Russell, Karl S., Army**
Ruttenberg, Max, 303 Cooper st., Camden
**Samter, Max, Army**
Santor, Daniel, 22 Taunton av., Berlin
Saunders, Orris W., 1700 Broadway, Camden
Schall, Reuben E., 7th & Elm sts., Camden
Scheffler, Wilhelm A. H., 511 Cooper st., Camden
**Schellenger, Edward A. Y., Army**
Schrack, Helen F., 216 N. Fifth st., Camden
**Schwartz, Henry C., Army**
Seiberling, Jos. D., 225 Redman av., Haddonfield
**Seto, Stanford P. T., Army**
**Shaen, Edward, Army**
**Shafer, Albert H., Army**
Shafer, F. William, 634 Penn st., Camden
**Sharp, Reuben L., Navy**
Shaw, Ernest B., 811 Collings av.,W.Collingswood
Sheaffer, Clinton P., 241 Kings H'way,E.,Had'nf'd
Shemeley, Wm. G., Jr., 7 Haddon av., Camden
Sherk, A. Lincoln, 2647 Westfield av., Camden

Shipman, James S., 514 Cooper st., Camden
Shope, Edward P., 807 Wilson Bldg., Camden
Shull, Elliott C., 517 Cooper st., Camden
Sieber, Isaac G., 204 Merchant st., Audubon
**Smith, Bertram H., Army**
Smith, James D., 701 N. 6th st., Camden
**Smith, Wilbur A., Army**
**Snagg, William T., Navy**
Snape, William J., 24 1st av., Runnemede
Sochacki, Alexander, 1478 Mt.Ephraim av.,C'md'n
**Stein, Joseph M., Army**
**Stephenson, Daniel H., Army**
**Stetser, Leland M., Army**
Stone, Frank P., Laurel rd., Laurel Springs
**Sufrin, Emanuel, Army**
Summerill, Garnett, 330 Cooper st., Camden
**Swiecicki, Martin E., Army**
**Tatem, Henry R., Jr., Army**
Thompson, P. H., 4612 W'stf'd av.,PennsaukenTp.
**Traganza, Robert W., Army**
**Warwick, Ralph A., Army**
Watkins, George R., La Pierre rd., Magnolia
**Waugh, Bascom S., Army**
Weimann, Max L., 803 Station av., Haddon Hgts.
**West, David H., Navy**
West, Gordon F., 2840 Mabel st., Tucson, Arizona
Whalen, Edward C., 942 Cooper st., Camden
Wheatland, Marcus F., Jr., 757 Kaighn av.,Camd'n
Wiant, Herman E., 120 Windsor av., Haddonfield
Wiggins, Ulysses S., 1025 S. 4th st., Camden
Williams, Wm. C., Black Horse Pk., Haddon Hts.
Wilson, Isam E., 110 Chapel av., Merchantville
**Wilson, Lester R., Army**
Winter, Carl M., 1518 Collings rd., Camden
Wright, Ralph S., 428 Richey av., W. Collingsw'd
Wroblewski, Benj. M., 1166 Thurman st., Camden

**Number of Active Members and basis of representation, 206.**

### HONORARY MEMBERS

Clements, Lavinia B., Haddonfield
Day, Grafton E., Collingswood
Eaton, Arthur T., Haddon Heights
Lyon, Leslie C., Magnolia
Marcy, John W., Merchantville
Osmun, Milton M., Audubon
Pratt, William H., Camden
Van Sciver, John E. L., Haddonfield

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## CAPE MAY COUNTY (5)

Society organized December 18, 1883. Eight regular meetings each year. Meets on second Tuesday, October to May inclusive. Semi-annual meeting in October. Annual Meeting in May.

### ACTIVE MEMBERS

**Bernheisel, Louis E., Army**
Brooks, George M., Main st., Cape May Ct. House
**Cameron, C. Paul, Army**
Cohen, Maurice B., Pine & Pacific avs., Wildwood
Cooper, Jules, 723 Washington st., Woodbine
Crowe, Aldrich C., 735 Atlantic av., Ocean City
**Cryder, Millard C., Army**
Dandois, George F., 220 E. Wildwood av., Wildw'd
Darby, C. Eugene, 620 Atlantic av., Ocean City
Eisenhower, J. S. D., 154 E. Spicer av., Wildwood
Haines, F. B. Lane, 503 Ninth st., Ocean City
Haines, Willits P., 503 Ninth st., Ocean City
Hirsch, Arthur, 811 DeHirsch av., Woodbine
Hornstine, Harry H., 4004 Pacific av., Wildwood
Hughes, Frank R., 29 Ocean st., Cape May
**Hughes, Samuel B., Army**
Mace, Margaret, 2410 Atlantic av., N. Wildwood
Monosson-Friedland, Ida, 200 N. East av., Vinel'd
Moon, Alexander C., 126 Decatur st., Cape May
Pettit, Herschel, 807 Wesley av., Ocean City
Smith, Marcia V., 821 Wesley av., Ocean City
Steel, Wm. A., 3300 N. Broad st., Philadelphia, Pa.
Stuart, Alexander A. S., 4614 Landis av.,SealsleC'y
Townsend, John B., 824 Wesley av., Ocean City
**Way, Clarence W., Army**
Whiticar, John H., Box 235, Ocean City

**Number of Active Members and basis of representation, 26.**

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## CUMBERLAND COUNTY (6)

Society organized June 16, 1816. Meets on the second Tuesday of October, December, February, April and June. Annual Meeting in April. Special scientific meetings are held in the evening in November, January, March and May.

### ACTIVE MEMBERS

**Aitken, Frank J., Army**
Anastor, Herbert C., 641 Wood st., Vineland
Baeon, Mary, 278 E. Commerce st., Bridgeton
Baker, Hugh W., 8th & Elmer sts., Vineland
Bauman, Kenneth R., 213 N. 3rd av., Millville
Bellak, Ellis R., Lecsburg
Berkowitz, Benjamin, 188 E. Commerce st.,Bridgeton
Bostwick, Delazon S., Cumberland Hotel, Bridgeton
Branin, Howard S., 200 W. Main st., Millville
Butcher, Charles, Heislerville
Cornwell, Alfred, 265 N. Laurel st., Bridgeton
**Corson, Kenneth E., Army**
**Cunningham, Charles, Jr., Army**
Davies, George A., 53 Front st., Elmer
Day, Samuel T., Main st., Port Norris
**DeSantis, Orazio J., Army**
Friedland, Arnold J., 200 N. East av., Vineland
Fromkin, Charles, 20 Bank st., Bridgeton
Garrison, W. Sherman, Main st., Cedarville
Gray, Charles M., 6th & Grape sts., Vineland
**Greene, Edwin C., Army**
Gricco, Anthony L., 830 Elmer st., Vineland

Henry, Norman, 739 Wood st., Vineland
Kauffmann, Louis J., 228 N. 2nd st., Millville
Knowles, James S., 318 N. Second st., Millville
**Kratka, William H., Army**
Kump, Albert B., 31 W. Commerce st., Bridgeton
**Loder, Horace B., Army**
Loper, John C., 129 Atlantic av., Bridgeton
Lore, Harry E., Main st., Cedarville
Lyon, Earl C., 194 E. Commerce st., Bridgeton
**Magolda, Anthony F. ,Army**
Marchione, Nicholas E., 105 S. East av., Vineland
Mayhew, Charles H., 329 Pine st., Millville
Mezzetti, Alfred F., 220 S. 6th st., Vineland
Miller, H. Garrett, 203 E. Main st., Millville
Myatt, Leslie E., 98 N. Pearl st., Bridgeton
Neal, Charles B., Pine & 3rd sts., Millville
**Pino, Anthony, Army**
Ramsey, F. Muriel, 310 E. Pine st., Millville
Reeves, J. Franklin, 55 East av., Bridgeton
**Rosen, Sol, Army**
**Rosenthal, Bernice D., Army**
**Schwartz, Leon J., Army**
Scott, Leonard G., 496 E. Commerce st.,Bridgeton
Sharp, Charles E., Main st., Port Norris
Sheppard, Alfred G., 309 Broad st., Elmer
Sheppard, Muse A., 102 Main st., Elmer
Sheppard, Thomas S., 21 E. Vine st., Millville
**Shirlock, Margaret E., Army**
Siegel, Sidney L., 227 N. 2nd st., Millville
Thalheimer, Edward J., 7th & Plum sts., Vineland
Thomas, George N., 712 Wood st., Vineland
Walker, Ada H., 635 Landis av., Vineland
Walker, H. Burton, 635 Landis av., Vineland
Ware, Carl N., Bridgeton rd., Shiloh
Whaland, Berta, 117 Atlantic st., Bridgeton
Wilson, Charles W., 636 Wood st., Vineland
Wilson, Herbert H., 24 Bank st., Bridgeton
Winslow, John H., 27 S. Valley av., Vineland
Woodruff, Dare, 611 Elmer st., Vineland

**Number of Active Members and basis of representation, 61.**

### HONORARY MEMBERS

Cornwell, Alfred, Bridgeton
Elmer, Matthew K., Bridgeton
Simkins, Raymond, Bridgeton
Wainwright, Frederick P., Bridgeton
Weithaase, Helen E., Vineland

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## ESSEX COUNTY (7)

Society organized June 4, 1816. Meets second Thursday of each month, Octber to May, inclusive. Annual Meeting is second Thursday in May.

### ACTIVE MEMBERS

Abel, Arthur R., Orange Memorial Hosp., Orange
Abrams, Abram B., 299 Clinton av., Newark
**Adelman, Benjamin B., Navy**
**Adelman, Nathan, Army**
Agnew, Hobart M., 17 Plymouth st., Montclair
**Albano, Edwin H., Army**
**Albano, Frank J., Army**
Albano, Joseph, 535 North 7th st., Newark
Alcamo, John H., 215 Littleton av., Newark
Alexander, Walter G., 48 Webster pl., Orange
**Alford, Ralph I., Army**
Allan, James S., 144 Harrison st., East Orange
**Allen, Chester B., Jr., Navy**
Alling, Frederic A., 15 Washington st., Newark
Altman, Charles D., 53 Lincoln Park, Newark
Ambrose, Anthony, 31 Lincoln Park, Newark
**Anderson, Robert C., Army**
**Anderson, William A., Navy**
Angelillo, Marc C., 169 Bloomfield av., Newark
Antonius, Nicholas A., 27 W. Market st., Newark
**Antopol, William A., Army**
Anuario, Charles B., 365 S. Center st., Orange
**Applebaum, Irving L., Army**
Areson, Wm. H., 153 Bellevue av., Upper Montcl'r
**Arons, Harry, Army**
Ash, Samuel, 866 So. 13th st., Newark
Asher, Maurice, 186 Clinton av., Newark
Aszody, Paul, 340 Waverly av., Newark
Averbach, Friedrich, 490 Stuyvesant av.,Irvingt'n
Bachmann, Wm., 87 Hillcrest ter., East Orange
Bacote, Ernest F., 78 Barclay st., Newark
Bagg, Linus W., 31 Lincoln Park, Newark
**Baime, Jules E., Army**
**Baiocchi, Pascal J., Army**
Baker, Maclyn F., 987 Sanford av., Irvington
Baldwin, Samuel H., 626 Clinton av., Newark
**Balsamo, Joseph J., Army**
**Balson, Zachary D. B., Army**
**Barbella, Joseph D., Navy**
**Barkhorn, Charles W., Army**
Barkhorn, Henry C., 45 Johnson av., Newark
**Barnard, Frank G., Army**
Barrett, John E., 25 Elwood pl., Newark
**Barrett, Joseph F., Army**
Baum, Felix, 10 Elm court, South Orange
Baum, Samuel, 10 Osborne ter., Newark
**Bauman, Everett O., Army**
Bauman, Rush C., 92 High st., Nutley
**Becker, Martin, Army**
Beer, Sanel, 48 Wilson av., Newark
Beling, C. Abbott, 15 Washington st., Newark
Beling, Christopher C., 111 Clinton av., Newark
Bell, Horace O., Essex Co.IsolationHosp.,Belleville
Bell, Thomas, 340 Belmont av., Newark
Belott, Louis V., 276 Springdale av., East Orange
**Bender, Louis, Army**
Bengelsdorf, Aron, 29 Clinton pl., Newark
Bennett, Wm. F., Essex Mt. Sanatorium, Verona
Berardinelli, Carmine G., 92 8th av., Newark
**Berg, Samuel, Army**
Berger, Wm. A., 346 Roseville av., Newark
Bergman, Meyer W., 31 Lincoln Park, Newark
**Berlin, Morris R., Army**
Berman, H. Robert, 299 Clinton av., Newark
**Bernhard, William G., Army**
Bernstein, Arthur, 668 Clinton av., Newark
Bernstein, Julius, 584 S. 10th st., Newark
**Besson, Franklin J., Navy**
Beyer, Othmar J., 42 Laurel av., Irvington
Bianchi, Angelo R., 184 Hunterdon st., Newark
Bien, Frank A., 999 Clinton av., Irvington
Bigelow, Elizabeth F., 120 Prospect st., So. Orange

**Bigelow, Nelson S., Navy**
**Binder, Charles I., Army**
Birdsall, Clarence A., 9 Smull av., Caldwell
Bissett, John V., 29 Hawthorne av., East Orange
**Biunno, Anthony J., Army**
Blackburne, George, 490 Central av., Newark
Blanchard, Kenneth, 144 Harrison st., E. Orange
Blaustein, Maurice L., 859 S. 13th st., Newark
**Bleiberg, Jacob, Army**
Block, Marcus T., 177 Bloomfield av., Newark
Block, Max, 48 N. Fullerton av., Montclair
**Block, Milton, Army**
**Bocchini, Joseph A., Army**
Bokor, Emery, 819 S. 12th st., Newark
Bolten, Bernard, 291 Osborne ter., Newark
Bonomo, Michael J., 587 S. 10th st., Newark
**Borsher, Irving P., Army**
Bove, Joseph, 306 Lincoln av., Orange
Brackett, Elizabeth R., 371 Franklin av., Nutley
Bradford, Stella S., 26 N. Mountain av., Montclair
Brady, Raymond J., 36 Walnut st., Newark
Brakeley, Elizabeth, 71 Myrtle av., Montclair
Brams, William M., 7 Madison av., Newark
**Brandman, Otto, Army**
Braun, Gustav A., 24 Centre st., South Orange
Breitstadt, Charles A., 157 Elwood av., Newark
**Bremer, Kenneth M., Army**
Brien, William M., 449 Main st., Orange
Briggs, Henry, 144 Harrison st., East Orange
Brim, Anne S., Edgemere Hotel, East Orange
Broadnax, Mary E., 140 Roseville av., Newark
Brodkin, Eva T., 365 Osborne ter., Newark
**Brodkin, Henry A., Army**
**Brodkin, Louis A., Army**
**Brooke, Charles R., Army**
**Brotman, Harry, Army**
Brotman, Morton M., 90 Avon av., Newark
Brown, Chester R., 22 Midland av., Arlington
Brown, Chester T., Prudential Ins. Co., Newark
Brown, Edward V., 9 Park av., Caldwell
Brown, Harold W., 27 S. Fullerton av., Montclair
**Brown, Lewis W., Navy**
Browne, George F., 14 Old Quarry rd., Up. Mtclr.
**Bruning, Richard H., Navy**
Brunkow, Charles D., 31 Lincoln Park, Newark
**Buckley, Jeremiah L., Army**
Buckner, Roscoe W. H., 20 Rose st., Newark
Buermann, August, III, 103 Lincoln Park, New'rk
Bull, Louis M., 92 Heller Parkway, Newark
Bull, William J., 98 Park st., Montclair
Burke, Leonard P., 30 Lakeside av., Verona
Burke, Stephen E., 212 First av., Newark
Burne, John J., 17 Gould av., Newark
**Burpeau, William P., Army**
**Burrill, Benjamin B., Jr., Navy**
Burrus, Thomas P., 50 Thomas st., Newark
**Burstein, Frank, Army**
Burstein, Leo Q., 702 S. 15th st., Newark
Burstein, Rachel, 31 Lincoln Park, Newark
Busch, Herman, 38 Johnson av., Newark
Bush, Archer C., 40 Union st., Montclair
**Butan, Louis, Army**
Buvinger, Chas. W., 50 Washington st., E. Orange
**Byck, Louis, Army**
Bythewood, Alton E., Jr., 145 W. Market st.,New'k
Cacciarelli, Robert A., 517 Roseville av., Newark
**Caggiano, Anthony P., Navy**
Cahill, Laurence A., 361 Lafayette st., Newark
**Calasibetta, Charles J., Army**
**Caldwell, Donald M., Army**
Caldwell, Julius A., 45 S. Mountain av., Montclair
**Calvert, William C., Army**
Camche, Leo J., 250 Renner av., Newark
Cameron, Arthur E., 59 Somerset st., Newark
Cameron, Edwin A., 186 S. Burnett st., E. Orange
Campbell, Everette L., 144 Harrison st., E.Orange
Campbell, Wm., 144 Harrison st., East Orange
Cantalupo, Emidio, 95 Nichols st., Newark
Cantelmo, Alphonse L., 144 Harrison st., E.Orange
**Caprio, Orlando G., Army**
Caputo, Anthony R., 301 Wash'gton av.,Belleville
Carbone, Francesco N., 440 Central av., Orange
**Cardwell, Edgar P., Army**
Carlisle, Paul E., 763 Broad st., Newark
Carman, Fletcher F., 21 Parkway, Montclair
Carpenter, Charles A., 30 Francis pl., Caldwell
Carr, Josephus C., 75 13th av., Newark
**Carrigan, Francis P., Army**
Carrol, Wilfred, 51 Ingraham pl., Newark
Casale, John B., 359 Bloomfield av., Newark
Cassini, Henry C., 27 Tremont av., East Orange
Castellano, Martin G., 330 Roseville av., Newark
**Cerone, Daniel M., Army**
Cerreto, Frank R., 395 Roseville av., Newark
Cestone, Canio, 521 Pompton av., Cedar Grove
Chamberlain, Aims R., 30 Lenox pl., Maplewood
Chamberlain, Richard R., 30 Lenox pl., Maplew'd
Champlin, Paul M., 43 S. Arlington av., E. Orange
Chattin, J. Franklin, 195 Boyden av., Maplewood
Cherashore, Harry N., 363 Centre st., Nutley
**Chernus, Jack, Army**
**Cheskin, Louis J., Army**
Chiger, Alexander S., 621 High st., Newark
**Chimacoff, Hyman, Army**
**Chmelnik, Abraham G., Navy**
**Christoph, Francis T., Army**
**Ciccone, Edwin L., Navy**
Clarken, Joseph A., 27 Ingraham pl., Newark
Claus, C. Hermann, 776 S. 19th st., Newark
**Clement, Baxter L., Army**
**Clinton, Joseph A., Navy**
**Coburn, J. Wesley, Army**
**Coffin, Henry F., Army**
Coghlan, Jasper, 540 Parker st., Newark
Cohen, I. Elvin, 561 Elizabeth av., Newark
Cohen, Maurice, 106 Valley rd., Montclair
Cohen, Max, 60 Ridge rd., North Arlington
Cohen, Meyer J., 118 Johnson av., Newark
**Cohen, Sidney A., Army**
Cohen, Sidney L., 29 Girard pl., Newark
**Cohen, Sidney P., Army**
Cohn, George M., 867 S. 11th st., Newark
Cohn, Hermann, 393 Clinton av., Newark
Cohn, Royal M., 740 Clinton av., Newark
**Coleman, Russell M., Army**
**Colmer, M. Jonas, Army**
Colsh, LeRoy L., 612 Ridgewood rd., Maplewood
**Colton, Ethan T., Jr., Army**
Comando, Harry N., 690 Clinton av., Newark
Connamacher, Harold S., 671 Springf'd av.,New'k
Connolly, John J., 180 Ballantine Pkwy., Newark
Connolly, Richard N., 117 Fifth st., Newark
Cook, Hugh F., 21 Roseville av., Newark
Cooper, David P., 62 S. 10th st., Newark
Cordasco, Peter, 517 Roseville av., Newark
**Cornish, Charles H., Army**
Coughlan, Ella A., 10 Oakwood av., Orange
Coughlin, Frank J., 100 Magnolia av., Arlington
**Covino, Louis L., Army**
Cox, John C., 55 Woodland rd., Maplewood
Cox, Wm. W., 79 S. Fullerton av., Montclair
Crane, Charles G., 78 Farley av., Newark
Crapanzano, Domenico, Essex Co. Hosp., CedarGr.
Craster, Charles V., Plane & William sts., Newark
Crawford, Georgina U., 65 Prospect st., E. Orange
Crecca, Anthony D., 376 Roseville av., Newark
Crecca, William D., 111 Park av., Newark
Cregar, John S., 150 Harrison st., East Orange
Crossfield, Henry C., 144 Harrison st., E. Orange
Crystell, Edward H., 4 Hawthorne av., Nutley

Curtis, Arthur W., 144 Harrison st., East Orange
Curtis, Elbert A., 65 Central av., Newark
**D'Addario, Anthony R., Army**
**D'Agostini, Alfred J., Army**
**D'Agostini, Robert J., Army**
D'Alessandro, Arthur J., 15 Salem st., Newark
D'Ambola, Philip R., 21 S. Sixth st., Harrison
D'Amico, Thomas V., 16 Grove av., Verona
Dane, Charles, 61 Scotland rd., South Orange
Dane, John, 61 Scotland rd., South Orange
D'Angelo, Jos. C., 330 Washington av., Belleville
**Dann, Frederick J., Army**
**Dante, Pasquale, Army**
**Danzis, Louis, Army**
Danzis, Maximillian, 31 Lincoln Park, Newark
**Darby, I. Kermit, Army**
Darden, Walter T., 149 W. Kinney st., Newark
Daron, Simeon, 31 Lincoln Park, Newark
**Davidson, Henry A., Army**
Davies, George W., 35 Fairview av., Verona
Davis, Louis, 825 S. 10th st., Newark
**Davis, Thomas C., Navy**
Davis, William J., 144 Harrison st., East Orange
Dear, Abraham L., 23 Synott pl., Newark
DeFronzo, Morando, 180 Fairmount av., Newark
**DeGerome, James H., U. S. P. H. S.**
Deignan, William L., 257 Dodd st., East Orange
Delaney, Oscar M., 59 Seely av., Arlington
Del Deo, Nicholas V., 49 State st., Newark
DeLeonardis, James V., 94 Jefferson st., Newark
Del Guercio, Olindo, 342 Clifton av., Newark
**DeLia, Emilio, Army**
**Del Negro, Albert E., Army**
**DeMichele, Roland V., Army**
Denes, Oscar, 402 Centre st., Nutley
**DePalma, Anthony F., Navy**
DePhillips, Benedict R., 228 Clifton av., Newark
Dessauer, Joseph, 105 Shanley av., Newark
**DeTroia, Frederick C., Army**
**Deutel, Oscar R., Army**
DeVincentis, Henry, 285 Henry st., Orange
**Devlin, Arthur D., Army**
Devlin, Hugh J., 72 Thomas st., Newark
Dias, Joseph L., 17 Lombardy st., Newark
Dieffenbach, Richard H., 570 Mt. Pr'sp't av.,New'k
**Diener, Samuel, Army**
**DiFino, Felix J., Army**
DiGiacomo, Harry E., 195 Hunterdon st., Newark
**DiGiacomo, William H., Army**
Dinge, Ferdinand C., 67 S. Munn av., East Orange
**DiNorcia, Joseph, Army**
Dodd, Edward L., 157 Forest st., Belleville
Donahue, William J., 71 S. Ninth st., Newark
Donchi, Sol. M., 9 Madison av., Newark
**Donnelly, John H., Army**
Dowds, Samuel C., 218 Walnut st., Montclair
Dragonetti, Elvige N., 177 Clifton av., Newark
Dranow, Paul, 233 Franklin av., Nutley
Drapkin, Berta, 31 Lincoln Park, Newark
Dreskin, Jacob L., 172 Lyons av., Newark
DuBois, Morris G., 769 High st., Newark
Duffy, Edward P., Jr., 158 Beech st., Nutley
Dulany, Theodore L., 170 W. Market st., Newark
Dulin, Everett V., 144 Harrison st., East Orange
**Dunn, Theodore B., Army**
Durchlag, E. Nelson, 12 Myrtle av., Irvington
Dwork, Harold K., 1 Hansbury av., Newark
Eagleton, Wells P., 15 Lombardy st., Newark
Ebenfeld, Samuel W., 344 High st., Newark
Echikson, Joseph I., 31 Lincoln Park, Newark
Eck, Daniel B., 144 Harrison st., East Orange
Edelen, James J., 100 S. Munn av., East Orange
Ehrlich, Edward, 838 So. 13th st., Newark
Ehrlich, William E., 31 Lincoln Park, Newark
Eichler, Bernard B., 221 Midland av., Montclair
**Eigen, Louis A., Army**
Ein, William B., 31 Lincoln Park, Newark
**Einhorn, Samuel E., Army**
Eisenberg, David S., 31 Lincoln Park, Newark
Eisenstodt, Lester W., 31 Lincoln Park, Newark
Ellis, Arthur J., 282 Broad st., Newark
Emerson, Linn, 303 Park av., Orange
Emmer, S. Wolfe, 31 Lincoln Park, Newark
Englander, Charles, 41 Hillside av., Newark
English, John T., 110 Yale av., Irvington
Epler, Don A., 45 Hillside av., Newark
Epstein, Harry B., 31 Lincoln Park, Newark
**Epstein, William M., Army**
**Erdman, George L., Army**
**Erler, Robert E., Army**
Ervin, Millard B., 36 Canterbury lane, Westfield
**Etheridge, Charles H., Army**
Evans, Chas. H., 144 Harrison st., East Orange
**Evans, David P., Navy**
Ewing, Harvey M., 31 Trinity pl., Montclair
**Fader, Ferdinand, Army**
**Fager, Rudolph O., Army**
Failing, Brayton E., 31 Lincoln Park, Newark
Fanburg, Sol J., 31 Lincoln Park, Newark
Farkas, Morris, 163 High st., West Orange
Farr, Irving L., 214 Walnut st., Montclair
Fasano, Giovanni, 194 S. 7th st., Newark
Faughnan, Rose C., 97 High st., Passaic
Fava, Philip V., 355 Sanford av., Newark
Fechner, Julius, 362 Clinton av., Newark
Fein, Bernard, 585 Elizabeth av., Newark
Feinsod, Samuel N., 1305 Clinton av., Irvington
**Feldman, Frank H., Army**
Fendrick, Edward, 17 Watson av., East Orange
**Fenichel, Benjamin, Army**
Ferguson, Wm. E., City Convalesc't Home, New'k
Fern, Samuel S., 122 Elizabeth av., Newark
Feuer, Joseph A., 653 Elm st., Arlington
Fink, A. Elston, 489 High st., Newark
Fink, Irving E., 129 Lyons av., Newark
Finkel, Joshua, 853 S. 11th st., Newark
**Finkelstein, Abe S., Army**
Finkler, Rita S., 35 Leslie st., Newark
**Finnerty, Urban R., Navy**
**Fischbein, Martin M., Army**
Fischer, Edward J., 29 Ashwood ter., West Orange
Fischer, Louise, 31 Lincoln Park, Newark
**Fischer, David D., Army**
Fischman, Harold H., 326 Avon av., Newark
Fitzpatrick, Edw. F., 546 W. Market st., Newark
**Flanagan, John J., Army**
Flax, Charles H., 71 Baldwin av., Newark
**Flax, Ira I., Army**
**Flax, Jacob L., Navy**
Fleischmann, Viola G., 103 Scotland rd., S.Orange
Fleming, Joseph A., 247 Claremont av., Montclair
Floody, Robert J., 324 Kingsland st., Nutley
Flower, Morrie A., 39 Lincoln Park, Newark
Flynn, Edward A., 176 Washington av., Belleville
**Foley, James F., Army**
Ford, Theodore R., 144 Harrison st., East Orange
Forsyth, Kenneth C., 8 Ziegler Tract, CarneysP't
Fort, J. Irving, 306 Roseville av., Newark
**Forte, Daniel L., Army**
Forte, Frank S., 318 Roseville av., Newark
**Fortunato, Samuel J., Army**
Fost, William H., 107 Franklin st., Belleville
Foster, Herbert W., 2 Erwin Park, Montclair
Fowler, Royale H., 744 Broad st., Newark
Frame, Dorothy L., 15 Highland av., Glen Ridge
**Francy, Donald G., Army**
**Franklin, Frank A., Army**
**Fratantuno, Michael J., Army**
**Freeman, George C., Army**
Freeman, Richard D., 317 Carteret pl., Orange

Freinkel, Jacob, 2 Hillside av., Newark
Friedlander, Kurt F., 25 S. Munn av., E. Orange
**Friedman, Harry, Navy**
Friedman, Hyman, 1096 Sanford av., Irvington
**Friedman, Milton, Army**
**Friedrich, Adam H., Navy**
Fritsch, Alfred, 82 Lyons av., Newark
Froelich, Joseph C., 74 Ingraham pl., Newark
**Fruchtbaum, Robert P., Navy**
Furman, Benj. A., 31 Roseville av., Newark
Furst, Nathan J., 299 Clinton av., Newark
**Galioto, Frank M., Army**
Gamba, Joseph, 388 Fairmount av., Newark
Gambacorta, Leopoldo, 397 N. 13th st., Newark
Ganley, Arthur J., 390 Park av., East Orange
Ganot, Frank I., 392 Ridge st., Newark
Gardam, Joseph W., 16 Longfellow av., Newark
Gardner, Kenneth E., 45 Fremont st., Bloomfield
Gauch, William, 177 Ellwood av., Newark
Gaylor, Earl L., Jr., 144 Harrison st., E. Orange
Geannette, Ernest D., 14 Harrison av., Montclair
Gehl, Sidney H., 65 Wolcott ter., Newark
**Gelb, Jerome, Army**
Geller, Samuel, 696 High st., Newark
**Gencher, Benjamin, Army**
Gennell, Ernest, 298 Parker st., Newark
George, Melbourne E. W., 744 Broad st., Newark
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Schults, Anna R., 25 Abington av., Newark
**Schurman, Francis H. C., Army**
**Schwartz, Harold, Navy**
**Schwartz, Mortimer L., Army**
**Schwartz, Ralph A., Army**
Scott, Norman M., 31 Clinton st., Newark
Scott, R. Hunter, 205 Roseville av., Newark
Scranton, Chas. W., 59 Washington st., E. Orange
Seidler, Victor B., 16 Plymouth st., Montclair
Seidman, Edwin A., 580 High st., Newark
**Seidman, Joshua I., Army**
Seifert, Edwin A., 415 Ridgewood av., Glen Ridge
Sellitto, Anthony M., 115 Connett pl., S. Orange
Selvaggi, Carlo, 82 Congress st., Newark
Sena, Marie A., 549 S. Orange av., Newark
Seward, William H., 188 S. Essex av., Orange
Shack, David N., 712 Clinton av., Newark
**Shack, Maxwell H., Army**
Shaner, Ralph D., 94 Hillside av., Nutley
Shannon, Jas. B., 66 S. Fullerton av., Montclair
Shannon, Lardner M., 66 S. Fullerton av., Montc'r
Shapiro, Louis, 146 Broad st., Newark
**Shapiro, Ralph N., Navy**
**Shapiro, Samuel A., Army**
Shaul, Frederick G., 10 Washington st., Bloomfield
**Shaul, John F., Navy**
Shaw, John J., 511 Prospect st., Maplewood
**Shaw, Ned, Army**
**Sheclner, Isadore, Army**
**Sheehan, Daniel C., Army**
Sherman, A. Russell, 671 Broad st., Newark
**Sherman, Arthur E., Army**
Sherman, Elbert S., 671 Broad st., Newark
**Shill, Benjamin, Army**
**Shlionsky, Herman, Army**
**Shor, David M., Army**
**Shreehan, Hubert F., Navy**
**Shulman, Murray W., Navy**
**Sicgel, Jack G., Army**
Siegel, Jacob W., 96 S. 10th st., Newark
**Silberner, Herbert B., Army**
**Silver, Harry B., Army**
**Silverman, S. Andrew, Army**
Silverstein, Benj. J., 32 Hillside av., Newark
Silverstein, Jacob M., 73 Main st., Millburn
Simmons, Albert V., 720 Prospect st., Maplewood
Simms, George F., 541 Page av., Lyndhurst
**Simon, Henry, Army**
**Simon, Ludwig L., Army**
Simonson, Louis, 202 Osborne ter., Newark
Singer, Max., 147 Johnson av., Newark
Sisson, Nelson W., 144 Harrison st., East Orange
Skwirsky, Joseph, 170 Hawthorne av., Newark
Slavin, Paul, 31 Lincoln Park, Newark
Smalley, Sara D., 530 Clifton av., Newark
**Smalzried, Elmer W., Navy**
Smarzo, Marjorie M., 46 Vernon ter., East Orange
**Smith, Byron J., Army**
**Smith, Charles H., Navy**
Smith, Christopher A., 295 Montg'm'ry st.,Bl'mf'd
Smith, Ellis L., Essex Co. Isolation Hosp.,Bellev'le
Smith, Harold W., 179 Lincoln av., Orange
Smith, Henry G., Essex Co. Hosp., Cedar Grove
Smith, Joseph J., 325 13th av., Newark
Smith, Leonard H., 32 Washington st., E. Orange
Smith, Nelson M., 144 Harrison st., East Orange
Smith, Thayer A., Forest dr., Short Hills
Snavely, Earl H., Newark City Hospital, Newark
Snook, Lee O., Jr., 8 Hedden ter., N. Arlington
**Sobin, Julius, Army**
Solk, Arthur G., 88 Clinton av., Newark
Solomon, Harold, 79 Shanley av., Newark
Somers, Fred L., 144 Harrison st., East Orange
**Sonnenberg, Arthur, Army**
Sorock, Emil M., 310 Roseville av., Newark
Soschin, Samuel J., 31 Lincoln Park, Newark
Spallone, Joseph C., 123 Mt. Prospect av., Newark
**Sperling, Irving L., Army**
Spinner, Samuel L., 190 Clinton av., Newark
Sprague, Edward W., 86 Washington st., Newark
Staehle, Richard H., 34 Lyons av., Newark
Stahl, Alfred, 55 Lincoln Park, Newark
Stahl, Charles, 659 Sanford av., Newark
Staknevich, John H., 658 Grove st., Irvington
Statman, Arthur J., 17 Leslie st., Newark
Steiner, Edwin, 31 Lincoln Park, Newark
Steiner, Herbert, 650 Stuyvesant av., Irvington
Stern, David A., 127 Lyons av., Newark
Stern, Max E., 2 Milford av., Newark
Stern, Morton M., 24 Girard pl., Newark
Stevens, Merton H., 58 So. Maple av., East Orange
Stewart, Robert G., 79 Midland av., Montclair
Stickles, Lloyd C., 49 Parkhurst st., Newark
Stiles, C. Campbell, 713 Park av., East Orange
**Stoddard, Gordon V., Army**
Stokes, Donald E., 120 Prospect st., South Orange
Stokes, Earle B., 144 Harrison st., East Orange
Stoll, George F., 330 Washington av., Belleville
Strack, Jerome A., 1 Scotland rd., South Orange
Strack, Vincent J., 1072 S. Orange av., Newark
Strasser, Hans A., 555 William st., East Orange
Straub, Herbert H., 242 Springdale av., E. Orange
Straus, Max, 87 Harrison pl., Irvington
**Strauss, Frederick, Army**
Strauss, Max, 190 Clinton av., Newark
Strauss, Wm. T., Jr., 6 Jerome pl., Upper Mtclr.
Streen, Morris E., 908 Bergen st., Newark
Strong, Alonzo P., 737 Mosswood av., Orange
Sturchio, Edoardo, 104 Ferry st., Newark
Sturchio, Eugenio, 178 Mt. Prospect av., Newark
Suesserman, Henry, 389 Lyons av., Newark
**Sullivan, William T., Navy**
**Sutton, Harold L., Army**
Sutton, Jos. G., Essex Co. Hosp., Cedar Grove
Swain, Richard D., Jr., 211 Roseville av., Newark
**Symes, Earl R., Army**
Szerlip, Leopold, 31 Lincoln Park, Newark
Szivos, Louis A., 106 Glenwood av., East Orange
Taff, Harry, 478 Orange st., Newark
**Taffet, William, Army**
**Tansey, W. Austin, Jr., Army**
Tarbell, Harold A., 13 Pennington st., Newark
Teeter, Charles E., 418 Orange st., Newark
Tenney, Albert S., 164 Harrison st., East Orange
Tepper, Victor, 2 Parkview ter., Newark
**Thomas, John H., Navy**
Thomison, Harry E., 605 Broad st., Newark
Thompson, Arthur F., 144 Harrison st., E. Orange
Thompson, Austin B., 479 Highland av., Orange
Thomson, Carroll S., Fair Oaks Sana., Summit
Thornhill, Arthur C., 47 Forest st., Montclair
**Thornley, William F., Army**
Tillis, Herman H., 31 Lincoln Park, Newark
Tilton, William R., 763 Broad st., Newark
**Tirrell, C. Malcolm, Navy**
Tobey, Franklin J., 11 Hazelwood av., Newark
**Tobey, John R., Army**
Toczek, Heinrich A., 391 Bergen st., Newark
**Tomee, Richard F., Navy**
**Torppey, John J., Army**
Trautwein, Charles F., 131 Nesbit ter., Irvington
Troedsson, Bror S., 188 S. Essex av., Orange
**Tuly, Ralph, Navy**
Tunis, Benno B., 22 Ingraham pl., Newark

Turi, Amedeo E., 57 Garside st., Newark
Turner, Charles F., 151 Grove st., Montclair
Tushnet, Leonard, 662 18th av., Irvington
**Tutela, Arthur C., Army**
Tutschulte, Ernest, 111 Mt. Pleasant av., Newark
Twitchell, Adelbert B., 162 S. Orange av.,S.Orange
Tymeson, Walter R., 310 Main st., Orange
Ulan, Oscar, 92 Fleming av., Newark
**Ulvestad, Lawrence E., Army**
Urbach, George, 181 Chancellor av., Newark
Valentin, Irmgard, 131 Harrison st., East Orange
Vallario, Frank A., 333 Clifton av., Newark
Vander Veer, H. Garrett, 295M'tgomery st.,Bl'mf'd
Van Emburgh, Geo. H., 575 Belgrove dr.,Arlingt'n
**Van Gieson, Edward J., Navy**
Vannatta, Geo. W., 226 N. Park st., East Orange
Van Ness, H. Roy, 444 Parker st., Newark
Verbeck, Geo. B., 20 Church av., BallstonSpa,N.Y.
Villanova, Ralph N., 266 S. 8th st., Newark
**Vincent, Nicholas F., Army**
**Virgilio, Anthony A., Army**
VonHofe, Frederick H., 75 Prospect st., E.Orange
Voorhees, Florence E., 140 Roseville av., Newark
Wagner, John, 48 Wilson av., Newark
Wakeley, Wm. E., 144 Harrison st., East Orange
**Waldron, Robert E., Army**
Walkenberg, Michael, 56 Clinton pl., Newark
Wallack, Charles A., 23 Treacy av., Newark
Wallhauser, Henry J. F., ShawFarm,Mt.Bethel,Pa.
Walsh, Charles R., 95 W. Northfield av.,Livingst'n
Walton, Ralph W., 102 Gates av., Montclair
Wambsganss, Magdalena, 44 Devine st., Newark
**Wangner, William F., Army**
Ward, Elisabeth B., 112 Chancellor av., Newark
Ward, Gertrude P., 41 Park pl., Bloomfield
Ward, William R., 112 Chancellor av., Newark
**Ward, William R., Jr., Army**
**Warner, Halsey F., Army**
Warner, Wm. H. A., 444 Central av., East Orange
Washington, William H., 321 High st., Newark
**Waterman, Samuel M., Army**
Weber, Francis C., 286 Mt. Prospect av., Newark
Weeks, Norman E., 159 Christopher st., Montclair
Weinmann, Max H., 714 Scotland rd., Orange
Weinstein, Francis S., 857 S. 11th st., Newark
Weinstein, Leopold, 82 Lyons av., Newark
Weinstein, Morris W., 942 Sanford av., Irvington
**Weinstock, Michael B., Army**
Weiss, Louis, 519 Springfield av., Newark
**Weiss, Mortimer H., Army**
Weiss, Selma, 2 Stratford pl., Newark
**Welkind, Allen A., Army**
Weller, Arthur, 19 Hillyer st., Orange
**Wesson, Harrison R., Navy**
Weston, Clifford G., 27 Woodland av., Glen Ridge
**Wheeler, William K., Navy**
Whelan, Edward P., 460 Franklin av., Nutley
White, Robert R., 144 Harrison st., East Orange
Wiener, David, 196 Weequahic av., Newark
Willan, Edward H., 74 S. Munn av., East Orange
Willey, F. Parker, 153 Roseville av., Newark
Williams, John J., 88 Walnut st., Newark
Willner, Irving, 18 Waverly av., Newark
**Willner, Philip, Army**
Willson, James H., 144 Harrison st., East Orange
**Wilson, John H., Jr., Navy**
Winter, Egon W., 825 S. 10th st., Newark
Wolf, Raymond E., 251 Ridgew'd av., Glen Ridge
Wolfe, Jacob S., 44 Watsessing av., Bloomfield
Wolfe, William W., 383 Mulberry st., Newark
**Wood, E. LeRoy, Army**
Woolf, Bernhardt H., 41 Hedden ter., Newark
Work, John L., Mountainside Hosp., Montclair
Wort, Frederick J., 1080 Broad st., Newark
Wrensch, Alexander E., 79 Valley rd., Montclair
Wright, Robert E., 55 S. Clinton st., East Orange
Wuerthele, Virginia E., 560 Mt. Pr'sp'ct av.,New'k
**Wujciak, Henry J., Navy**
Wurts, Margaret M., 27 Wellesley av., Up. Mtclr.
**Wurzel, Milton, Army**
Wyatt, Joseph H., 135 Clinton av., Newark
Wyker, Arthur W., 57 Park pl., Bloomfield
Wynder, Alfred, 654 Lyons av., Irvington
Yablonsky, Max, 30 Shanley av., Newark
Yadkowsky, Emanuel, 637 High st., Newark
**Yaguda, Asher, Navy**
**Yankowicz, Michael, Army**
Yates, Glen L., 270 Ridgewood av., Glen Ridge
**Yelin, Gabriel, Army**
**Yoskalka, Jack S., Army**
Young, I. Henry, 220 Columbia av., Irvington
Young, John H., 37 N. Fullerton av., Montclair
Zacher, Henry A., 685 High st., Newark
**Zager, Saul, Army**
Zehnder, A. Charles, 188 Roseville av., Newark
**Zimmer, William, Army**
**Zimmerman, Coler, Army**
**Zingali, John A., U. S. P. H. S.**
Zvaifler, Nathan, 46 Wilbur av., Newark
**Zweibel, Leonard, Army**
Zweigel, Isidore, 22 Monticello av., Newark
Zybulewski, Edmund A., 410 Bergen st., Newark

**Number of Active Members and basis of representation, 1224.**

## ASSOCIATE MEMBERS

Adelson, Edward, 201 Keer av., Newark
Auturino, Ralph R., 10 Harrison av., Montclair
Berney, Irving, 31 Lincoln Park, Newark
Berney, Ruth V., 16 Lyons av., Newark
Brewer, Catherine H., 112 Chancellor av., Newark
Edelson, Edmund, 127 Lehigh av., Newark
Faulkner, Mortimer S., Or. Mem. Hosp., Orange
**Glynn, S. Robert, Army**
Goldberg, Bernard R., 31 Lincoln Park, Newark
Haller, Olga, 182 Roseville av., Newark
Hillman, Ernest C., Jr., 15 Washington st., New'k
Jarvis, Daniel G., 31 Lincoln Park, Newark
**Kauder, Warren G., Army**
Kearney, Paul A., 23 Gladstone av., Newark
Linz, Curt, 431 Franklin av., Nutley
**Mancusi-Ungaro, Harold, Army**
McLaughlin, William B., 39 Quinby pl., W.Orange
Mele, Vincent, 275 S. 7th st., Newark
Modny, Michael T., 262 Ridgewood av.,GlenRidge
**Roston, Mark A., Army**
Starr, George R., Jr., 665 Berkeley av., Orange

### TRANSFERS

Browne, George F., from Michigan
Cooper, David P., from New York
Evans, Joseph O., to Union County
Gilbert, Harold F., from Alabama
Kinley, John W., from Connecticut
Mauer, Richard E., from Iowa
Rossi, Bartolomeo, to Somerset County
Work, John L., from Ohio
Ylvisaker, Lauritz S., to Pennsylvania

### RESIGNED

Roeber, William J.

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## GLOUCESTER COUNTY (8)

Society organized December, 1818. Regular meetings on third Thursday of each month, except June, July and August. Annual Meeting in May. Annual Social Session in October.

### ACTIVE MEMBERS

Barrows, Victor I., 316 N. Broadway, Pitman
**Black, Maskell B., Army**
Booth, George R., 219 Highland av., Westville
Bowersox, Clarence A., 509 N.Broad st.,Woodbury
**Broselow, Benjamin G., Army**
**Burkett, J. Paul, Navy**
Burkett, Wendell J., 16 W. Holly av., Pitman
Campo, A. Guy, 401 Broadway, Westville
Carpenter, Wm. H., 39 Aberdeen pl., Woodbury
Chalfant, Wm. P., Br'dway & Crafton av., Pitman
**Collins, Louis K., Army**
Davis, Clarence E., S. Academy st.,R.D.1,Glassb'ro
DiMarino, Anthony J., 735 Delaware st., Paulsboro
Diverty, Henry B., 38 Cooper st., Woodbury
**Faux, Frederick J., Navy**
Fisler, Charles F., 140 Maple st., Clayton
Fooder, Horace M., 110 Main st., Williamstown
**Gillis, Alfred G., Army**
Harris, William G., Main st., Mullica Hill
Hollinshed, Ralph K., 351 Broadway, Westville
**Hughes, Joseph F., Army**
Lintz, Sidney Z., 525 Kings Hwy., Swedesboro
Livengood, Baxter A., 64 Cooper st., Woodbury
McGuire, Wm. A., 29 W. Wash'gton st., Paulsboro
**Moore, Ralph L., Army**
Nelson, Harry, 36 Lupton av., Woodbury
Patterson, Isaac N., 230 Broadway, Westville
Pedrick, William W., 11 West st., Glassboro
**Rhoads, S. Creadick, Army**
Rogers, Dorothy M., 50 Cooper st., Woodbury
**Ruttenberg, Louis, Army**
Serri, Wm. S., 447 Kings Highway, Swedesboro
Sheets, Cecil C., 213 W. Broad st., Paulsboro
Sherman, Fuller G., 204 Delaware st., Woodbury
Sinexon, Henry L., 36 W. Broad st., Paulsboro
**Sirotta, E. Bernard, Army**
Sooy, L. Thomas, 202 W. Holly av., Pitman
Stewart, Irving J., 529 Kings Highway,Swedesboro
Ulmer, Chester I., 431 W. Broad st., Gibbstown
Underwood, J. Harris, 509 N. Broad st., W'dbury
**Venturo, Ralph C., Army**
Wandall, Frederick G., 50 E. High st., Clayton
Weems, Don B., 105 E. Mantua av., Wenonah
**Wentzell, J. Earl, Army**
**Whitaker, Henry J., Army**
Wood, Oran A., 128 W. Broad st., Paulsboro
**Wright, Herman W., Army**
Zapf, Reville D., 100 W. Mantua av., Wenonah

**Number of Active Members and basis of representation, 48.**

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## HUDSON COUNTY (9)

Society organized October 11, 1851. Meets first Tuesday evening of each month, October to May, inclusive. If a legal holiday, meeting to be held on next day Annual Meeting in May.

### ACTIVE MEMBERS

Adler, Joseph, 933 Avenue C, Bayonne
Africano, Julius V., 43 Columbia ter., Weehawken
**Agolia, Michael W., Army**
Ainsley, H. Bryson, 246 Union st., Jersey City
Alpert, Edward, 661 Jersey av., Jersey City
Alter, Nicholas M., 410 Fairmount av., Jersey City
Amdur, Louis A., 2540 Boulevard, Jersey City
**Angelo, Joseph A., Army**
Anrig, Grace E., 613 Summit av., Union City
**Arbeit, Sidney R., Army**
Arena, John, 9209 Boulevard, North Bergen
**Aria, Charles J., Army**
Aria, Michael H., 31 Glenwood av., Jersey City
**Arndt, Frank R., Army**
Aronowitz, Harry T., 923 Avenue C, Bayonne
**Artaserse, George V., Army**
Ash, Arthur F., 710 Boulevard, E., Weehawken
Atwell, David R., 920 Hudson st., Hoboken
Auriemma, Michele, 419 Adams st., Hoboken
**Bahnson, Conrad M., Army**
Bailyn, Emanuel, 400 60th st., West New York
Ballinger, Reeve L., 659 Kearny av., Arlington
Balsamo, Anthony J., 5016 Hudson av., W.NewY'k
Barbarito, Wm. N., 135 Bentley av., Jersey City
Barishaw, Samuel B., 25 Bentley av., Jersey City
**Barone, Francis A., Army**
Behrens, Herman H. E., 312 Webster av.,Jer.City
Ben-Asher, Solomon, 254 Bergen av., Jersey City
Benjamin, Harold C., 59 Crescent av., Jersey City
Berlin, Joseph I., 2600 Boulevard, Jersey City
**Betcher, Albert M., Army**
**Bigliani, Urban R., Army**
Bitten, Robert M., 33 Romaine av., Jersey City
Blakey, Abram P., 155 Wegman Pkwy., Jer. City

**Blum, Milton, Army**
Boland, Lucy E., 27 Washington av., Arlington
**Bonanno, Peter J., Army**
**Bookrajian, Edward N., Army**
Borrone, Milton G., 2624 Boulevard, Jersey City
**Borshaw, Hyman, Navy**
Bortone, Frank, 2765 Boulevard, Jersey City
**Boselli, Emile H., Army**
Botti, John A., 236 Summit av., Jersey City
Boyers, Sidney S., 4614 Boulevard, Union City
**Boyle, Francis L., Navy**
**Bradasch, George A., Army**
Brady, Thomas S., 678 Avenue C, Bayonne
Brady, William A., 412 44th st., Union City
Braitman, Max, 412 60th st., West New York
**Brauer, Selig L., Army**
Braunstein, Sigmund C., 424 57th st., W.NewYork
Braunstein, Wm. P., 1 Bellevue st., Weehawken
Brennock, Thos. McG., 3 Webster av., Jersey City
**Bresev, Morris, Army**
Brick, George J., 43 Cottage st., Jersey City
**Brignola, Gerald C., Army**
Brophy, Francis X., 55 Gifford av., Jersey City
Brozdowski, John J., 554½ Jersey av., Jersey City
Butler, Vincent P., 33 Bentley av., Jersey City
Campana, Francis A., 615 17th st., Union City
Campana, Vincent R., 386 Fairmount av., Jer. C'y
Cangemi, Vito F., 50 Glenwood av., Jersey City
Cannon, Edward A., 7512 Boulevard, No. Bergen
Caridi, Salvatore, 431 59th st., West New York
Carr, Mary B., 1 Astor pl., Jersey City
Catlaw, J. Kenneth, 254 Montgomery st., Jer.City
Chapman, Ellis J., 203 Danforth av., Jersey City
Chayes, Sydney, 980 Avenue C, Bayonne
Choffy, Sylvester A., 202 Bergen av., Jersey City
**Christian, Henry A., Army**
Cieri, Daniel S., 1515 Central av., Union City
Cohen, Herman, 489 Jersey av., Jersey City
Cohen, Herman N., 108 13th st., Hoboken
**Cohen, Samuel, Army**
**Cohen, Samuel A., Army**
**Connell, Emmet J., Navy**
Connell, John N., 26 Carlton av., Jersey City
Connolly, Thomas W., 921 Bergen av., Jersey City
Conti, Michael, 280 4th st., Jersey City
Conty, Anthony J., 318 48th st., Union City
**Cosgrove, Robert A., Army**
Cosgrove, Samuel A., 88 Clifton pl., Jersey City
**Coughlin, John P., Navy**
**Cowan, Joseph H., Army**
Cracco, Frederick A., 211 Palisade av., Union C'y
**Cricco, Carl F., Army**
Cufari, Carmine J., 725 18th st., Union City
Culver, S. Herbert, 75 Magnolia av., Jersey City
**Cupaiuoli, Richard A., Navy**
D'Acierno, Pellegrino A.,1708 P'lis'de av.,UnionC'y
Daly, Edmund J., 921 Bergen av., Jersey City
**Danielson, John J., Army**
**Davis, Daniel, Army**
DeFuccio, Charles P., 12 Duncan av., Jersey City
**DeFusco, G. Thomas, Army**
Deitmaring, Francis A., 7922 Blvd., N. Bergen
**Del Baglivo. Mario, Army**
**DeMarco, Silverino V., Army**
DeSevo, Gerard E., 108 Fairview av., Jersey City
Detrano, Salvatore J., 903 Wash'gton st.,Hoboken
DeVincenzo, F. Richard, 629 W'sh'gt'n st.,Hob'k'n
Dexter, Harriet E. T., 903 Avenue C, Bayonne
Donnelly, Joseph P., 58 Kensington av., Jer. City
Donohoe, Lucius F., 33 Dodge st., Bayonne
Donohue, Daniel J., 139 Highland av., Jersey City
Doody, William M., 19 Bentley av., Jersey City
**Doran, Ralph J., U. S. P. H. S.**
Doran, Wm. G., 2685 Boulevard, Jersey City
**Dougherty, Daniel D., Army**
Doyle, John J., 426 Fairmount av., Jersey City
**Driscoll, Raymond S., Army**
Duckett, Warren J., 21 Carlton av., Jersey City
Dukes, Howard R., 220 Kearny av., Kearny
Edwards, Lena F., 358 Pacific av., Jersey City
Elsasser, Theodore H., 7206 Park av., Woodcliff
Elwood, Benjamin J., 810 Boulevard, Bayonne
Enright, James G., 25 Kensington av., Jersey City
Ettinger, Samuel, 501 32nd st., Union City
Evans, J. Lawrence, 7117 Park av., Woodcliff
**Faber, Edward, Army**
Facciolo, Frank, 562 Boulevard, Bayonne
Faison, John B., 45 Glenwood av., Jersey City
**Fattel, Henry C., Army**
Fauquier, Leonard B., 172 Jewett av., Jersey City
**Federer, John J., Army**
**Feinberg, Harry, Army**
Felitti, Vincent J., 1006 80th st., North Bergen
**Feller, William, Army**
**Fenimore, Edward D., Army**
**Fialk, Harry, Army**
Ficke, Sylvia A., 884 Summit av., Jersey City
**Fifer, William T., Army**
Figurelli, Francis A., 88 Highland av., Jersey City
Fineberg, Jacob C., 50 Glenwood av., Jersey City
Finger, Frederick A., 943 Avenue C, Bayonne
Finke, Charles H., 317 York st., Jersey City
Finn, Frederick A., 921 Bergen av., Jersey City
Finn, Henry R. W., 84 Lembeck av., Jersey City
Flichtenfeld, Morris, 283 Fourth st., Jersey City
**Flicker, David J., Army**
Fliegel, Hilda C., 309 Baldwin av., Jersey City
**Frank, Herman I., Army**
Frank, Morris, 920 Avenue C, Bayonne
**Frank, Nathan, Army**
Franklin, I. Harold, 191 Palisade av., Jersey City
Freeman, Joseph, 146 W. 32nd st., Bayonne
**Freyberger, George A., Army**
Freymann, Walter, 5006 Hudson av., W.NewYork
Frieman, Hyman, 744 Avenue C, Bayonne
Frutig, Harold C., 508 80th st., North Bergen
Furman, Sol T., 344 Fairmount av., Jersey City
Garbarini, John G., Medical Center, Jersey City
**Gerne, Timothy A., Army**
**Gerner, Harry E., Navy**
Ghee, Euclid P., 115 Claremont av., Jersey City
Ginsberg, George, 624 Bloomfield st., Hoboken
**Gleason, Thomas P., Army**
Gleeson, William J., 640 Bergen av., Jersey City
Gnassi, Angelo M., 130 Wegman Pkwy., JerseyCity
Goldowsky, Ira, 23 Warner av., Jersey City
**Goldsmith, Alfred S., Navy**
**Goldstein, Joseph D., Army**
Goldstone, Karl H., 16 62nd st., West New York
Goodrich, Stewart L., 812 Avenue C, Bayonne
Gordon, Isaac L., 1815 Boulevard, Jersey City
**Gorenberg, Harold, Navy**
Granelli, Humbert A., 213 Garden st., Hoboken
Greenberg, Philip, 1902 Boulevard, Jersey City
**Greenberg, Solomon, Army**
Greene, Albert D., 915 Palisade av., Union City
**Greene, Harry, Army**
**Grieco, Emil H., Army**
Grossman, Morris, 921 Bergen av., Jersey City
**Grossman, Rubin, Army**
Grubowski, Joseph N., 562½ Jersey av., Jer. City
Gurland, Benjamin B., 146 W. 37th st., Bayonne
Gurley, Katharine A., 2671 Blvd., Jersey City
**Gutmann, Erwin K., Army**
Hall, Perry O., 2553 Boulevard, Jersey City
Halligan, Earl J., 254 Montgomery st., Jersey City
Halligan, Harold J., 254 Montgomery st., Jer. City
Halperin, David, 590 Bergen av., Jersey City
Halpern, Sophia L., 1311 Palisade av., Union City
**Handler, Harry, Army**

Harter, Louis F., 174 Bowers st., Jersey City
Hartwell, H. Ameroy, 777 Boulevard,E., W'hawk'n
Harvey, John W., 818 Avenue C, Bayonne
**Harz, William V., Army**
Hasking, Arthur P., 318 Montgomery st., Jer. City
**Hauptman, Harry, Navy**
Hekimian, Jacob H., 2314 Palis'de av., Weeh'wk'n
Hernandez, Manuel, 1974 Boulevard, Jersey City
Herradora, Juan R., 2787 Boulevard, Jersey City
Higgins, Gerald L., 86 Bartholdi av., Jersey City
Higgins, John T., 145 Highland av., Jersey City
Higgins, Thomas A., 2616 Boulevard, Jersey City
**Hillel, Joseph, Army**
**Hirsch, Solomon, Army**
**Holland, Moses H., Army**
**Hollywood, James L., Army**
Horowitz, Leo, 3644 Boulevard, Jersey City
**Howeth, John L., Navy**
**Imhoff, John G., U. S. P. H. S.**
Introcaso, Dominick A., 45 Crescent av., Jer. City
**Irving, Henry C., Army**
Ishkhanian, Nouri I., 6032 Palisade av.,W.NewY'k
Jacks, Oscar, 476 Mercer st., Jersey City
**Jaffe, Benjamin, Army**
Jaffe, Herman N., 2600 Boulevard, Jersey City
Jaffin, Abraham E., 41 Emory st., Jersey City
Jaques, J. Eugenia, 74 Waverly st., Jersey City
Jentz, John H., 67 Sherman pl., Jersey City
Johnson, Archie W., 169 Claremont av., JerseyC'y
Jones, Clement M., 454 Boulevard, Bayonne
Jones, J. Morgan, Valley rd., R. F. D., Oakland
Joseph, Benjamin M., 2771 Blvd., Jersey City
**Judy, Kenneth H., Army**
Justin, Arthur W., 41 Fulton st., Weehawken
**Kainer, Herbert, Army**
Kanengiser, Clifford H., 333 Fairmount av.,Jer.C'y
Kaplan, Herman B., 324 44th st., Union City
Katz, Jacob D., 38 Bentley av., Jersey City
**Katz, Sidney, Army**
Kearney, John V., 335 78th st., North Bergen
Keegan, Thomas D., 8 Gifford av., Jersey City
**Keeney, James C., Army**
Kelly, Bernard S., 1954 Boulevard, Jersey City
**Kelly, Harry R. J., Army**
**Kennedy, John W., Army**
Kiely, Eugene M., 800 Hudson st., Hoboken
**Kimmel, M. Leonard, Army**
Klein, Julius, 1513 Palisade av., Union City
Kolb, John M., 1611 Boulevard, North Bergen
Kooperman, Barnett, 321 60th st., West NewYork
**Kooperstein, Samuel I., Army**
Koppel, Joseph A., 42 Highland av., Jersey City
Kraemer, Samuel H., 309 Baldwin av., Jersey City
**Kraut, Arthur M., Army**
Kresch, Philip, 86 W. 34th st., Bayonne
**Kruger, Alfred L., Army**
Kuhlmann, Alvin E., 527 37th st., Union City
**Kun, Bertram, Army**
**Lakiszak, Roman T., Army**
**Landshof, Charles A., Army**
**Lane, Thomas F., Army**
Lange, Louis C., 50 Clifton ter., Weehawken
Largay, Arthur O., 937 Avenue C, Bayonne
Larkey, Charles J., 700 Avenue C, Bayonne
Lawsing, G. Conde, 443 66th st., West New York
Lease, Henry J., 111 74th st., Woodcliff
Leining, Albert, 45 48th st., Weehawken
Leir, J. Krevin, 2787 Boulevard, Jersey City
**Lepis, A. Albert, Navy**
**Levine, G. Irving, Army**
Linden, Mortimer H., 45 Clendenny av., Jer. City
Lindroth, Lawrence V., 4633 Blvd., N. Bergen
Lipshutz, Benjamin, 18 West 22nd st., Bayonne
**Lipshutz, Charles, Army**
Lisanti, Gaetano, 6109 Monroe pl., West NewYork
Little, Alonzo W., 120 Arlington av., Jersey City
**Lobban, Robert B., Army**
Londrigan, Joseph F., 832 Bloomfield st., Hoboken
**Londrigan, Joseph F., II, Army**
Long, Miles T., 2150 Boulevard, Jersey City
Loori, William A., 549 Pavonia av., Jersey City
Luczynski, Edward W., 28 E. 22nd st., Bayonne
Lupin, Edward E., 930 Boulevard, Bayonne
Lynch, Roland J., Mental Diseases Hosp.,Secaucus
**Lynn, Irving I., Army**
Macchia, Benjamin J., 358 Arlington av., Jer. City
MacDonald, John J., 348 Ogden av., Jersey City
**Mackin, John J., Army**
Madaras, John S., 870 Avenue C, Bayonne
Madison, L. Keith, 358 Pacific av., Jersey City
Malinowski, John, 50 Glenwood av., Jersey City
Markowitz, Benj. B., 116 Gifford av., Jersey City
Markowitz, Irwin B., 2157 Boulevard, Jersey City
**Marrella, Louis F., Army**
**Marshall, Frank A., Army**
Mastromonaco, Joseph D., 790 Avenue C,Bayonne
Matera, Joseph, 506 Garden st., Hoboken
Mathesheimer, Jacob L., 280 OldBerg'n rd.,Jer.C'y
Mathews, William J., 938 Hudson st., Hoboken
Matturri, Dominick A., 81 Gifford av., Jersey City
Maturi, Vincenzo E., 814 Boulevard, Bayonne
Maver, William W., 532 Bergen av., Jersey City
McCarron, James A., 341 Avenue A, Bayonne
McCarthy, Cornelius P., 887 Boulevard, Bayonne
**McCarthy, John J., Navy**
**McLean, Hugh A., Navy**
McLoughlin, Frank J., 558 Jersey av., Jersey City
**McLoughlin, John W., Army**
McNenney, Claudio E., 113 Fairview av., Jer. City
Meehan, George E., 117 Mercer st., Jersey City
Meltsner, Louis, 904 Hudson st., Hoboken
**Meltzer, Louis, Army**
Mersheimer, Christian H., 15 Reservoir av.,Jer.C'y
Meyer, William, 2128 New York av., Union City
Meyerson, Noah, 428 59th st., West New York
**Mickewich, Stephen A., Army**
Miller, Max H., 311 60th st., West New York
**Miller, Robert B., Navy**
**Mintz, Alvin R., Army**
Modarelli, Walter H., 312 36th st., Union City
**Monfort, Robert N., Army**
Morganstein, Louis K., 813 Avenue C, Bayonne
Monica, Louis A., 653 Avenue C, Bayonne
Moriarty, John F., 723 Washington st., Hoboken
Morley, Grace C., 64 Clifton ter., Weehawken
Morris, David G., 11 W. 26th st., Bayonne
**Muccia, John J., Army**
Mueller, George H., 102 Summit av., Jersey City
Mulvihill, William J., 275 Boulevard, Bayonne
Murphy, James M., 2757 Boulevard, Jersey City
Murphy, Leo J., 1814 West st., Union City
Murphy, Patrick H. W., 27 Jefferson av., Jer. City
Murray, Joseph A., 765 Avenue C, Bayonne
**Mustermann, Otto H., Navy**
Muttart, George W., 2521 Boulevard, Jersey City
Mutter, Alfred A., 75 Beech st., Arlington
**Nafash, Shafeek, Army**
Nalitt, David I., 28 West 33rd st., Bayonne
Newman, Abraham J., 132 Manhattan av., Jer.C'y
Nicholson, Frank P., 895 Summit av., Jersey City
**Noble, James J., Army**
Norton, James F., 58 Kensington av., Jersey City
Nuse, Edward F., 550½ Jersey av., Jersey City
Ockene, Abraham, 2415 Palisade av., Union City
O'Connor, John J., 2124 New York av., Union City
Oesterreicher, Desider, 427 Bergen av., Jersey C'y
O'Hanlon, George, Medical Center, Jersey City
Olpp, Arch. E., 1516 Bergenline av., Union City
**Ortolano, James J., Army**
**O'Shea, John J., Army**

**Osbrin, Henry, Army**
O'Sullivan, John R., 11 Quincy av., Arlington
Owen, Logan S., 1018 Hudson st., Hoboken
Pagliughi, John J., 401 18th st., Union City
Pearlstein, Frank, 325 60th st., West New York
Peckman, Abram, 56 Gifford av., Jersey City
**Penchansky, Samuel J., Army**
Pentel, Louis S., 307 60th st., West New York
Perkel, Louis L., 2801 Boulevard, Jersey City
Perlberg, Harry J., 921 Bergen av., Jersey City
**Perrone, Arthur F., Army**
Peters, Edgar A. P., 394 Bergen av., Jersey City
Peters, Menelaus, 921 Bergen av., Jersey City
Peterson, Chas. A., 921 Washington st., Hoboken
**Piltz, George F., Army**
Pindar, Frederick S., 7500 Park av., Woodcliff
Pindar, William A., 7523 Broadway, N. Bergen
Piskorski, Abdon V., 604 Jersey av., Jersey City
Plavin, Nathan J., 8010 Boulevard, No. Bergen
Pollak, Berthold S., 100 Clifton pl., Jersey City
Pontery, Herbert B., 89 Bowers st., Jersey City
**Potter, Benjamin P., Army**
Povalski, Alex. W., 1925 Boulevard, Jersey City
**Price, H. Preston, Army**
**Prince, Samuel, Army**
Purdy, Charles H., 35 Highland av., Jersey City
Pyle, Louis A., 89 Fairview av., Jersey City
Pyle, Wallace, 15 Exchange pl., Jersey City
Quaglieri, Charles L., 733 Park av., Hoboken
Quigley, Frederic J., 543 45th st., Union City
Quinn, John J., 921 Bergen av., Jersey City
Read, Donald B., 105 Hudson st., Jersey City
Reingold, Alexander, 221 Garden st., Hoboken
**Reznikoff, Leon, Army**
Rieck, Walter R., 379 Kearny av., Kearny
**Rienian, Aloysius P., Navy**
Riese, Jacob A., 6012 Palisade av., West NewYork
**Rosen, Charles E., Army**
**Rosenberg, Albert B., Army**
Rosenberg, Jacob, 692 Bergen av., Jersey City
Rosenstein, Jacob L., 568 Bergen av., Jersey City
Rubenstein, Eli, 800 Avenue C, Bayonne
**Rubenstein, Robert, Navy**
**Ruffer, Ralph A., Navy**
Rundlett, Emilie V., 79 Prospect st., Jersey City
Ruoff, Andrew C., 2414 New York av., Union City
Russell, David L., 690 Bergen av., Jersey City
Ruvane, Joseph J., 2787 Boulevard, Jersey City
**Sabini, Cecil F., Army**
Sacco, Anthony G., 2200 New York av., UnionCity
Sachs, Wilbert, 921 Bergen av., Jersey City
Sager, Harold, 19 W. 22nd st., Bayonne
Sakowski, John P., 20 W. 22nd st., Bayonne
Saladino, Anthony J., 427 15th st., Union City
Salmon, Edward F., 50 Gifford av., Jersey City
Santangelo, Stephen, 461 Jersey av., Jersey City
**Santosky, Benjamin B., Army**
**Saradarian, Albert V., Army**
Schapiro, Joseph, 3514 Palisade av., Union City
Scheer, Eli, 7500 Bergenline av., North Bergen
**Schenker, Benjamin N., Army**
Schenker, Israel N., 3697 Boulevard, Jersey City
Schept, Samuel S., 523 37th st., Union City
Schlein, August, 707 Park av., Hoboken
Schneider, Harry M., 89 Gifford av., Jersey City
Schneider, Louis A., 412 61st st., West New York
Schuchner, Wm. F., 550½ Jersey av., Jersey City
Schuck, Traugott J., 58 Ninth st., Hoboken
Schulman, Abraham S., 4518 Blvd., Union City
**Schwartz, Harold B., Army**
Schwarz, Berthold T. D., 2787 Blvd., Jersey City
**Schwarz, Henry J., Army**
Schwarz, John, 4 Kingswood rd., Weehawken
**Schwarzwald, Irving, Navy**
Sciarrillo, Louis F., 105 Newark st., Hoboken
Sciorsci, Edward F., 609 Bloomfield st., Hoboken
**Scott, John J., Army**
Scott, Samuel G., 141 Bergen av., Jersey City
Seligmann, Fred S., 501 32nd st., Union City
Selinger, Samuel, 413 60th st., West New York
Shapiro, Nathaniel J., 212 Palisade av., Union C'y
**Shapiro, Saul J., Army**
Sheeran, Vincent J., 101 Bentley av., Jersey City
Shook, Benjamin E., 284 Bergen av., Jersey City
Shulman, Nathan L., 538 45th st., Union City
**Siegel, Lester, Army**
Sigman, George, 254 Union st., Jersey City
**Silich, Robert L., Army**
**Simeone, Peter A., Army**
**Simpson, David B., Army**
Singer, Sina S., 3443 Boulevard, Jersey City
Sinnott, Gerald W., Medical Center, Jersey City
Skrypski, Joseph M., 2756 Boulevard, Jersey City
**Smith, Arthur B. R., Navy**
Snyder, W. Jay, 74 Columbia ter., Weehawken
Solomon, Louis, 7 Tonnele av., Jersey City
**Spano, Frank, Navy**
**Spath, William H., Army**
**Spohn, Eugene L., Navy**
Sprague, Seth B., 301 York st., Jersey City
**Stankiewicz, F. Stanley, Army**
Starr, Benjamin, 96 Sherman place, Jersey City
**Stefansin, Frank, Navy**
Stein, Albert, 600 80th st., North Bergen
Stein, Jacob M., 68 Columbia ter., Weehawken
Stockfisch, Robert H., 3637 Boulevard, Jersey City
Stokes, Anthony T., 819 First st., Secaucus
Street, Daniel B., 27 Woodlawn av., Jersey City
Stuart, William C., 518 Hudson st., Hoboken
Sullivan, James A., 19 Kensington av., Jersey City
Sulouff, S. Henry, 662 Newark av., Jersey City
**Sussman, Harold, Army**
Swiney, Juliana C., 325 Avenue C, Bayonne
Swiney, Merrill A., 325 Avenue C, Bayonne
**Taft, Herman L., Army**
Talty, Francis, 1011 Bloomfield st., Hoboken
Talty, John C., 935 Washington st., Hoboken
Tataryan, Hovsep, 2024 New York av., Union City
**Temes, J. Howard, Army**
Terwedow, Walter G., 1510 Willow av., Hoboken
Thomas, Ralph B., 793 Montgomery st., JerseyC'y
Tidwell, Harold F., 229 60th st., West New York
Tomaiuoli, Michele, 19 76th st., North Bergen
**Toth, Elmer F., Army**
Tyndall, Hugh H., 83 Highwood ter., Weehawken
Urevitz, Abraham, 2415 New York av., Union City
**Utkewicz, Edmond A., Navy**
**Varriano, John L., Navy**
Visconti, Joseph A., 105 Newark st., Hoboken
Vostrosablin, Nicholas A., 121 Grand st., Jer. City
**Wallack, Eli A., Army**
Walscheid, Arthur J., 404 38th st., Union City
Waters, Edward G., 39 Gifford av., Jersey City
Watman, Anthony J., 2784 Boulevard, Jersey City
**Weber, Laura E., Navy**
Weber, Walter D., 305 23rd st., Union City
Weigele, Carl E., 143 East State st., Trenton
**Weiss, Abram, Navy**
Weiss, Morris J., 734 Avenue C, Bayonne
Wheeler, James A. V., 85 Van Reypen st., Jer.C'y
White, Hugh M., 901 Summit av., Jersey City
**White, Thomas J., Army**
Wichman, Heins, 2672 Boulevard, Jersey City
**Wilcox, Frank A., Army**
Woelfie, Henry E., 907 Summit av., Jersey City
**Wolbert, Charles M., Army**
Woltz, Sidney, 2206 New York av., Union City
Woodruff, Stanley R., 16 Enos pl., Jersey City
Yanowitz, Bernard, 135 Bergen av., Jersey City
Yeaton, Wm. L., Jr., 204 11th st., Hoboken

**Yontef, Reuben, Army**
**Yudkoff, William, Army**
**Yunek, William P., Jr., Army**
Zbar, Joseph E., 2690 Boulevard, Jersey City
Zitani, Alfred M., 937 Washington st., Hoboken

**Number of Active Members and basis of representation, 489.**

### HONORARY MEMBERS

Connell, John, Jersey City
Dillingham, Willis I., Oakland
Gille, Hugo, Jersey City
Older, Benjamin, Miami Beach, Florida
Rosecranz, James M., Hoboken
Sexsmith, George H., Los Angeles, California
Smith, Alexander L., Jersey City
Stout, J. Phillip, Jersey City

### TRANSFERS

Arena, John, from New York
Peters, Menelaus, from Wisconsin
Talty, Francis, from Massachusetts

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## HUNTERDON COUNTY (10)

Society organized June 12, 1821. Meets on fourth Tuesday of January, April, July, and October, April being the Annual Meeting.

### ACTIVE MEMBERS

Baker, Philip W., High Bridge
**Bambara, Aurelius J., Army**
Beatty, Hannah J., Clinton Farms, Clinton
Boothby, I. Roland, Clinton
Boyer, Charles G., Annandale
Christensen, Alexander H., Lebanon
Clark, Frank G., White House Station
Coleman, Austin H., Clinton
Crooks, William J., III, N. J. St. Hosp.,Gl.Gardn'r
Ctibor, Vladimir F., Califon
Decker, Frederick H., Frenchtown
English, Samuel B., N. J. State Hosp., GlenGardn'r
Fluck, Paul H., 73 N. Union st., Lambertville
Fritz, John F., Jr., 95 Main st., Flemington
Fuhrmann, Barclay S., 10 Main st., Flemington
**Garfinkel, Abraham, Army**
**Germain, Raymond J., Army**
Hamilton, Lloyd A., 46 York st., Lambertville
Henry, George, 33 Mine st., Flemington
Jenkins, Arthur M., 701 Harrison st., Frenchtown
Knox, Howard A., New Hampton
Lane, Edgar W., 46 Main st., Bloomsbury
McCorkle, William E., Ringoes
**Merrill, Edwin D., Army**
**Moran, John F., Jr., Army**
Mullins, Roy L., 305 Harrison st., Frenchtown
Salmon, Leon T., Lambertville
**Shangold, Jack E., Army**
Stolow, Alan A. J., N. J. State Hosp., Glen Gardn'r
Tompkins, Grenelle B., 52 Broad st., Flemington

**Number of Active Members and basis of representation, 30.**

### HONORARY MEMBERS

Morrison, J. Bennett, Vista, California
Scammell, Frank G., Trenton
Sommer, George N. J., Trenton

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## MERCER COUNTY (11)

Society organized May 23, 1848. Meets on second Wednesday of each month except July, August, and September, at 9:00 p. m., in the Stacy-Trent Hotel, Trenton. Annual Meeting in December. Annual Banquet in November.

### ACTIVE MEMBERS

Abey, Wm. J. H., 65 S. Main st., Pennington
Ackley, David B., 21 N. Clinton av., Trenton
**Albert, Perry, Army**
Anthony, David W., 201 Witherspoon st.,Princet'n
Applegate, Edw. T. R., 1125 Greenw'd av.,Trenton
Applesteln, Robert, 568 E. State st., Trenton
Aronis, Harry R., 18 Oak lane, Trenton
Ashley, Harmon H., 20 Nassau st., Prlnceton
Austin, Henry J., 96 Bellevue av., Trenton
**Barlow, John D., Army**
Barrows, Arthur M., 440 Hamilton av., Trenton
Barry, R. Grant, 908 W. State st., Trenton
**Bayne, Joseph K., Army**
Beairsto, Everett B., 224 W. State st., Trenton
**Belfer, Jacob J., Army**
Belford, Ralph J., 90 Nassau st., Princeton
Bellis, Horace D., 437 E. State st., Trenton
**Bennett, Robert E., Army**
**Bergsma, Daniel, Army**
Berman, Jacob J., 409 Market st., Trenton
Berry, Leonard M., 205 Nassau st., Princeton
Blackwell, Enoch, 28 W. State st., Trenton
Blaugrund, Samuel, 833 W. State st., Trenton
Blum, Joseph M., 128 Mill st., Trenton
**Bonnet, W. Laurence, Army**
**Borrella, Domenic D., Army**
Buckley, Richard T., Jr., Peddie Sch'l, Hightstown
**Burbidge, J. Raymond, Army**

Burns, Joseph R., 254 S. Olden av., Trenton
**Burroughs, Edmund W., Army**
**Byer, M. Yale, Navy**
**Carabelli, A. Albert, Army**
Carroll, C. Walter, 125 Centre st., Trenton
Carroll, William V., 211 Academy st., Trenton
Cella, Charles F., 359 Hamilton av., Trenton
**Charleroy, Durant K., Navy**
Chesner, Wm. A., 1111 Hamilton av., Trenton
Chianese, C. Chester, 464 Hamilton av., Trenton
Clark, Alice L., 206 W. State st., Trenton
Cohan, Charles C., 217 W. Hanover st., Trenton
Cohan, Joseph, 217 W. Hanover st., Trenton
**Cohen, Herman, Army**
**Cohen, William, Army**
**Colavita, James J., Army**
Collins, Henry J., 1160 Hamilton av., Trenton
Comfort, John B., 50 S. Clinton av., Trenton
Commini, Frank F., 741 Centre st., Trenton
Corio, George A., 307 S. Clinton av., Trenton
Corrigan, Patrick H., 1720 S. Broad st., Trenton
**Cotton, Henry A., Jr., Army**
Cottone, Rosario J., 683 Princeton av., Trenton
Cowlbeck, Harry D., 224 W. State st., Trenton
Cox, Harold C., 208 Stockton st., Hightstown
D'Arcy, Walter E., 545 E. State st., Trenton
Davenport, Irwin P., 545 W. State st., Trenton
Davis, Harold L., 178 W. State st., Trenton
**Davis, John E., Jr., Army**
Davison, Royden W., 205 W. State st., Trenton
Dean, Guy K., Jr., Princeton rd., Plainsboro
**Deitz, Joseph R., Army**
**Dembinski, T. Henry, Army**
Denelsbeck, J. Otis, 878 E. State st., Trenton
**Dimun, John T., Army**
**Dodge, James T., Army**
**Doranz, Harold K., Army**
Drezner, Henry L., 507 S. Warren st., Trenton
**Eames, William N., Army**
**Elias, Elmer J., Army**
**Engelhart, Ferdinand K., Army**
**English, Harrison F., III, Army**
Epstein, Rubie, 606 Perry st., Trenton
Ernest, Richard B., 240 W. State st., Trenton
Fabian, Paul L., 520 Princeton av., Trenton
Farmer, Walter D., 28 S. Main st., Allentown
Fessler, A. James, 1544 S. Broad st., Trenton
**Fine, Sydney G., Army**
**Finegan, Paul J., Army**
**Finkle, Lester J., Army**
Fiorello, Joseph R., 689 Princeton av., Trenton
**Fluck, David A., Army**
**Forer, Robert, Army**
**Franzoni, Andrew E., Army**
Friedman, Max, 849 W. State st., Trenton
Friedman, Meyer H., 526 N. Clinton av., Trenton
Friedmann, Leonard L., 484 Princeton av., Trent'n
Fuchs, Jacob N., 1267 S. Broad st., Trenton
Garwood, Norman W., Main st., Crosswicks
**Gindhart, John H., Navy**
Goldberg, Benjamin M., 1156 E. State st., Trenton
Goldman, Leo L., 325 Market st., Trenton
**Graham, Ernest E., Army**
Guglielmelli, Angelo D., 449 Hamilton av., Trent'n
**Guidotti, Frank P., Army**
Hafetz, M. Morris, 114 Centre st., Trenton
Haggerty, D. Leo, 227 N. Warren st., Trenton
**Hammell, Frank M., Navy**
Haney, John J., 850 Hamilton av., Trenton
Harman, James R., 824 W. State st., Trenton
Harman, William J., 740 W. State st., Trenton
Harrop, George A., 33 Cleveland lane, Princeton
**Hess, George A., Army**
Hiden, Joseph C., 199 Nassau st., Princeton
**Hirschfield, Bernard A., Army**
**Horhovitz, George I., Army**
**Hunter, Floyd D., Army**
Hutchinson, A. Dunbar, 913 W. State st., Trenton
Hutchinson, Geo. F., 55 Mercer st., Hamilton Sq.
Ivins, William C., 455 W. State st., Trenton
**James, J. Thomas, Army**
Janoff, Henry, 626 Perry st., Trenton
Jaspan, Samuel C., 820 Division st., Trenton
Johnson, John F., 120 Buckingham av., Trenton
Kachdorian, Vartan, 935 Brunswick av., Trenton
Kinczel, John A., 971 S. Broad st., Trenton
Klempner, Paul, 637 Greenwood av., Trenton
Kline, Joseph J., 733 Hamilton av., Trenton
**Kohn, Joseph J., Army**
**Kohn, Ralph B., Navy**
**Kondor, Joseph S., Army**
Koplin, Nathaniel H., 142 W. State st., Trenton
Kustrup, John F., 1418 S. Broad st., Trenton
**Lapin, Louis P., Army**
**Lapin, Samuel B., Army**
**Larsson, Evert A., Navy**
Lavine, Barney D., 630 N. Clinton av., Trenton
Lavine, Sidney B., 144 W. State st., Trenton
Leshin, Harry, 564 S. Main st., Hightstown
Lettiere, Anthony J., 425 E. State st., Trenton
Levin, Louis, 651 W. State st., Trenton
Levy, Irvin, 222 W. State st., Trenton
Light, Arthur B., Lawrenceville Sch'l, Lawr'nc'v'le
Little, William R., 493 W. State st., Trenton
**Lloyd, Samuel J., Army**
Lynch, Donald C., 885 Stuyvesant av., Trenton
MacDermid, Lynden E., 506 Farnsw'th av., Bordent'n
Magee, Harold S., New Jersey State Hosp., Trenton
Magson, Albert E., 302 S. Main st., Hightstown
Majeski, Henry J., 930 Brunswick av., Trenton
McCandliss, Wm. K., N. J. State Hospital, Trenton
**McCarthy, William P., Army**
McCullough, John H., 523 E. State st., Trenton
McGuigan, Francis A., 212 N. Warren st., Trenton
Means, Paul B., N. J. State Hospital, Trenton
Miller, Earle K., 2502 Nottingham way, Trenton
Miller, Gerald H., N. Main st., Cranbury
**Miller, Reginald C., Army**
**Miller, Samuel R., Army**
**Minschwaner, George G., Jr., Army**
Mitchell, Charles H., 1100 W. State st., Trenton
Mitskas, Theo. V. J., 1329 Greenwood av., Trenton
**Moriconi, Albert F., Army**
Mountford, Wm. E., 215 N. Warren st., Trenton
Munro, Jeannette, 2 Queenston pl., Princeton
Murphy, James A., 312 Bellevue av., Trenton
Murto, Thomas V., 117 Buckingham av., Trenton
Nayfield, Romald C., 974 S. Broad st., Trenton
Nonziato, Frank A., 50 Centre st., Trenton
North, Harry R., 160 W. State st., Trenton
Ogden, Andrew E., 1829 Greenwood av., Trenton
O'Neill, Joseph F., 41 E. Broad st., Hopewell
O'Rourke, James J., 871 Stuyvesant av., Trenton
Pantaleone, Joseph, 504 Hamilton av., Trenton
Parker, Horace N., 72 N. Clinton av., Trenton
Pessel, Johannes F., 224 W. State st., Trenton
Peterson, Walter R., 312 W. State st., Trenton
Pierson, Carl L., 395 W. State st., Trenton
**Pierson, Joseph R., Army**
Pinerman, Robert B., 308 W. State st., Trenton
Pittman, Allen R., N. J. State Hospital, Trenton
Potter, Ellen C., 301 W. State st., Trenton
Powis, Ethel M., 198 W. State st., Trenton
Poyas, Morton L., 306 W. State st., Trenton
**Preece, John D., Army**
Proctor, Francis E., 332 W. State st., Trenton
Purcell, Ernest F., 800 Stuyvesant av., Trenton
Ragany, Joseph, 966 S. Broad st., Trenton
**Rainey, Willard G., Navy**
**Rampona, Joseph M., Army**

Reisinger, Paul B., 369 W. State st., Trenton
Rita, James J., 235 S. Clinton av., Trenton
Rogers, Laurence H., Donnelly Mem.Hosp.,Trent'n
**Rose, William G., Army**
Rowan, Henry M., 224 W. State st., Trenton
**Sackin, Stanley, Army**
Salvatore, Joseph T., 324 Hamilton av., Trenton
Salway, Benjamin, 321 S. Broad st., Trenton
Scammell, Frank G., 40 S. Clinton av., Trenton
Scasserra, Benedict B., 163 Nassau st., Princeton
Schildkraut, Jacob M., 170 W. State st., Trenton
Seely, Roy B., 104 N. Clinton av., Trenton
Seitzick-Robbins, H. E., 723 W. State st., Trenton
Sekerak, Albert J., 984 S. Broad st., Trenton
Shear, M. Murray, 1158 E. State st., Trenton
Sica, L. Samuel, 431 E. State st., Trenton
Siemion, Theophilis R., 1005 Brunsw'k av.,Trent'n
Sill, John B., 942 W. State st., Trenton
Silver, E. Drew, 136 Stockton st., Hightstown
Sinton, John Y., Imlaystown
Slack, Clarence J., 230 W. State st., Trenton
Smith, Frank W., 1238 S. Clinton av., Trenton
Smith, W. Henley, 126 W. State st., Trenton
**Snegireff, Leonid S., Army**
Sommer, Geo. N. J., 120 W. State st., Trenton
**Sommer, Geo. N. J., Jr., Army**
Spradley, Jeems B., N. J. State Hospital, Trenton
Stabile, John A., Grand av., West Trenton
Steel, John M., N. J. State Hospital, Trenton
Stein, Louis A., 226 W. State st., Trenton
Storaci, Frank S., 715 Hamilton av., Trenton
Summers, Alfred D., 180 Nassau st., Princeton
**Sutnick, Theodore B., Army**
Swern, Nathan, 399 W. State st., Trenton
Swertfeger, Herbert W.,22 N.Greenw'd av.,Hopew'l
**Tenney, Luman H., Navy**
**Tomec, Otto C., Army**
Treiber, Benjamin A., 219 W. State st., Trenton
Tretter, Hans L., 501 W. State st., Trenton
Urbaniak, Henry S., 883 Brunswick av., Trenton
Vaczi, Stephen, 983 S. Broad st., Trenton
Vanneman, Joseph S., 45 Princeton av., Princeton
**Vento, Sebastian J., Army**
Vol-Tretter, Marta, 501 W. State st., Trenton
**Waldron, Edward L., Army**
**Walsh, Thomas J., Army**
Warter, Peter J., 717 W. State st., Trenton
Waters, Chas. H., 928 W. State st., Trenton
**Watov, Samuel E., Army**
Watson, Fred'k S., 238 W. State st., Trenton
Watts, Wilbur, 436 E. State st., Trenton
**Wayman, Bernard R., Army**
West, Edgar L., 443 E. State st., Trenton
Wiesler, Howard M., Drawer N, Trenton
**Wikoff, John L., Army**
Williams, Harry D., 829 W. State st., Trenton
Wilner, Arthur S., 205 Market st., Trenton
**Wilner, Irving, Army**
Wittenborn, W. F. J., 1635 Brunswick av., Trenton
**Wolff, Herbert M., Army**
**Yaeger, Leslie A., Army**
York, Wilbur H., 87 Battle rd., Princeton
Zimskind, Joshua N., 210 W. State st., Trenton

Number of Active Members and basis of representation, 241.

### ASSOCIATE MEMBERS

**Bernstein, Bertram, Army**
**Boudwin, Norman K., Army**
Dzienis, John, 1767 S. Broad st., Trenton
Edwards, Walter R., 22 Annabelle av., Trenton
Folmer, Edward, 730 S. Olden av., Trenton
**Franklin, Charles M., Army**
Gahan, Emanuel, 178 W. State st., Trenton
Granger, James R., 110 Spring st., Trenton
**Gribbin, James A., Army**
Hofbauer, Ernest, 695 Parkway av., Trenton
Lapin, Mathew R., 628 W. State st., Trenton
Morris, Leroy, Jr., 88 Spring st., Trenton
Quackenbos, Harrie M., N. J. State Hosp.,Trenton
Seaton, Stuart P., 45 Vandeventer av., Princeton
Straus, Walter, State Hospital, Trenton
**Usher, Glenn S., U.S.P.H.S.**

### HONORARY MEMBERS

Fell, Alton S., Trenton
MacFarland, Burr W., Trenton
Pierson, Theodore A., Hopewell
Taylor, Walter A., Trenton
Turner, Irvine F. P., Titusville
Wright, Howard E., Princeton

### TRANSFER

Clark, Charles E., to Connecticut

### RESIGNED

Stone, Robert G.
Taylor, Walter A.

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## MIDDLESEX COUNTY (12)

Society organized June 11, 1816. Meets on the third Wednesday of each month, October to June, inclusive. Annual Meeting in December.

### ACTIVE MEMBERS

Adler, Howard E., 103 Livingston av., New Bruns.
Anderson, John F., 195 College av., New Bruns'k
Avery, Philip S., Woodland ter., Bound Brook
**Balogh, William A., Army**
**Barbano, Alfred J., Army**
Barnett, Lester A., Grassl'nds Hosp.,Valhalla,N.Y.
Bassett, Lavern C., 320 New Market rd., Dunellen
**Belafsky, Henry A., Army**
**Berkow, Samuel G., Navy**
**Bowman, Ned O., Navy**

**Boyt, Theodore, Navy**
Breslow, Samuel, 157 Market st., Perth Amboy
Brody, Morton S., 57 Paterson st., New Brunsw'k
Brown, Fred'k L., 67 Livingston av., NewBr'nsw'k
Calvin, Charles H., 80 Commerce st., Perth Amboy
Carr, Alexander M., S. Main st., Metuchen
Clarke, Francis M., 116 New st., New Brunswick
**Cole, Nathaniel B., Navy**
Cooper, Irving J., 419 George st., New Brunswick
Cooperman, Eli L., 527 New Brunswick av., Fords
**Copleman, Benjamin, Army**
**Copleman, Hyman B., Army**
Cottrell, Judson G., 159 Market st., Perth Amboy
Csema, Emery J., 151 Somerset st., New Brunsw'k
**Degenhardt, Ira H., Army**
**Dieker, Howard E., Army**
Downing, Perley E., Sedgwick st., Jamesburg
**Downs, Louis S., Army**
**Dunham, Malcolm M., Navy**
Duschock, Edward F.,188 Wash'g'n st.,P'thAmboy
**East, Isaac C., Army**
Eulner, Elmer H., 216 Henry st., South Amboy
Fagan, James L., 51 Bayard st., New Brunswick
Fanelli, Antonio, 494 Compton av., Perth Amboy
Faulkingham, Ralph J., 61 Liv'gst'n av.,NewBrns.
Feher, Ladislas A. M., 177 Somerset st., New Brns.
Fine, Hyman P., 151 Market st., Perth Amboy
**Fine, Irvin J., Army**
Fishkoff, Alexander H., 132 Market st.,P'thAmboy
Fithian, George W., 266 High st., Perth Amboy
Forney, Norman N., 94 N. Main st., Milltown
Forney, Norman N., Jr., Stelle av., Milltown
**Friedenthal, Bernard, Army**
**Gadek, Stanley A., Army**
**Gadek, William V., Army**
Gauzza, Valentine P., 505 New Brunsw'k av.,Fords
Gerard, Arpad G., 502 Rahway av., Woodbridge
**Gessner, Gerard R., Army**
**Glasser, Benjamin F., Army**
Gobel, Stanley J., 79 Talmadge av., Middlesex Boro
Goldberg, Isidore, 303 N. Wash'gton av., Dunellen
Goldberg, Harry C., 7 Watchung av., Plainfield
Goldman Solomon, 161 Livingst'n av., NewBr'ns'k
Gorog, Nicholas M., 159 Bayard st., New Br'nsw'k
Greenwood, Wm. R., 118 Somerset st.,NewBr'ns'k
Grieve, James, 88 Market st., Perth Amboy
**Gurshman, Sol, Army**
Gutowski, Jos. M., 433 Brace av., Perth Amboy
Haight, Harry W., 118 Raritan av., Highland Park
Hauber, Eugene A., 198 Washington rd.,Sayreville
Haywood, Henry, 49 Paterson st., New Brunswick
Henry, Frank C., Jr., 214 Smith st., Perth Amboy
**Hesseltine, Clair E., Navy**
Hilker, George F., 258 Maple st., Perth Amboy
Hinton, Samuel H., 123 Main st., Sayreville
Hofer, Clarence J. M., 463 Main st., Metuchen
**Hoffman, Charles W., Army**
Hoffman, Florentine M., 91 Bayard st., New Brns.
Howell, E. Gaylord, 120 New st., New Brunswick
**Howley, Barth, Jr., Navy**
Hunt, Melvin M., 140 Jackson st., South River
**Hutner, Cyril I., Navy**
**Jablonski, John J., Army**
**Jacobson, Murray B., Army**
**Karshmer, Nathan, Army**
Kay, Albert E., 221 High st., Perth Amboy
**Kelly, Leo J., Army**
Kemeny, Imre, 48 Pulaski av., Carteret
Kleiber, Estelle E., 131 Livingston av.,NewBruns.
Klein, Alexander, 215 High st., Perth Amboy
Klein, Edward F., 136 Market st., Perth Amboy
Klein, William, 85 Bayard st., New Brunswick
Kler, Joseph H., 151 Livingston av., New Bruns'k
Koelsch, Fred'k J., 14 Kirkpatrick st., NewBruns.
**Kohut, George J., Army**
**Krafchik, Louis L., Army**
**Kramer, Bernard M., Navy**
Kramer, Samuel E., 254 State st., Perth Amboy
**Lang, Joseph, Army**
**Lavine, Samuel C., Army**
**Lazow, S. Manlius, Navy**
Leonard, George F., 63 N. 5th av., Highland Park
**Levinson, Reuben, Army**
Lewis, Collins E., 219 Seaman st., New Brunswick
Lief, Lawrence H., Gatzmer av., Jamesburg
London, William, 255 State st., Perth Amboy
Long, Pauline A., 22 Livingston av., New Bruns'k
**Lucey, James J., Navy**
Mangogna, Philip, 334 Barclay st., Perth Amboy
**Mann, Benjamin, Army**
Mann, Jacob J., 255 State st., Perth Amboy
Margaretten, Edward I., 280 Hobart st.,P'thAmb'y
Mark, Joseph S., 102 Green st., Woodbridge
Marvin, Dorothy H., 51 Livingston av., New Brns.
McCormick, Wm. H., Jr., 266 Market st., P'thAmboy
McGovern, John F., Jr., 24 Liv'gst'n av.,N'wBr'ns'k
McKiernan, Robt. L., 97 Bayard st., New Brunswick
McKinstry, John W., Railroad av., Jamesburg
McLeod, Neill S., 729 Raritan av., Highland Park
Meacham, Eugene A., 112 Stevens av., So. Amboy
Meinzer, Martin S., 147 Market st., Perth Amboy
Merrill, Charles F., 16 S. 3rd av., Highland Park
Messinger, Samuel, 31 Roosevelt av., Carteret
**Miller, George M., Army**
**Miller, S. David, Army**
**Morris, Carlyle, Army**
Nafey, Herbert W., 51 Livingston av., NewBruns'k
Naulty, Chas. W., Jr., 403 High st., Perth Amboy
Nieman, Solomon Z., 191 Livingston av.,NewBr'k
**Normand, Alphonse F., Army**
**O'Connell, James J., Navy**
**Panigrosso, Louis R., Navy**
Pansy, Abraham A., 12 Jackson st., South River
Pearson, J. Gerald, 116 Livingston av.,NewBr'ns'k
**Pellicane, Anthony J., Army**
Platt, Thomas H., 307 N. Washington av.,Dunellen
Reason, John J., 612 Roosevelt av., Carteret
**Reitman, Norman, Army**
**Richlin, Padie, Army**
**Rineberg, Irving E., Navy**
Rona, Maurice, 10 Kirkpatrick st., New Brunsw'k
Rothfuss, C. Howard, 574 Rahway av.,Woodbridge
Rothschild, Karl, 149 Livingston av., New Bruns'k
Rowland, John H., 159 New st., New Brunswick
**Rubin, Benjamin, Army**
**Rubin, William, Army**
Runyon, Laurence P., 80 Somerset st.,NewBruns'k
Salaky, William L., 387 Neville st., Perth Amboy
Sandella, Jos. F., 138 Livingston av.,NewBrunsw'k
Saulsberry, Chas. E., 75 Livingston av.,NewBruns.
**Schirber, Rene G., Army**
Scott, Frederick W., 103 Bayard st., New Bruns'k
Sender, Fannie, 193 Main st., South River
Shayevitz, Abraham S., 102 Main st., South River
Sherman, Wm. E., 88 Schureman st., New Bruns'k
Shull, John V., 184 Kearny av., Perth Amboy
Siegel, Isadore, 121 Market st., Perth Amboy
Silk, Charles I., 236 High st., Perth Amboy
Slobodien, Benjamin F., 233 High st., P'th Amboy
Smith, Ivan B., Georges rd., Dayton
Smith, John A., 106 Main st., South River
Smith, John V., 463 State st., Perth Amboy
Smith, Joseph A., Roosevelt Hospital, Metuchen
**Smith, Percy L., Army**
**Smith, Sydney F., Army**
**Sokoloff, Oscar J., Army**
**Spagnolo, Peter J., Army**
**Spritzer, Theodore D., Army**
**Steffens, Charles T., Army**
**Stein, William, Army**

Sullivan, Chas. J., 57 Paterson st., New Brunsw'k
Szuch, Nicholas, 159 Main st., South River
**Taber, Frederick S., Army**
Tisch, Leon, 28 S. 3rd av., Highland Park
**Toy, Calvert R., Army**
**Tucker, Sidney, Army**
Uhr, Jacques S., 127 Livingston av., New Bruns'k
Ulan, Jerome, Main st., Spotswood
Urbanski, Matthew F., 314 Wash'gt'n st.,P'hAmb'y
Vargyas, Joseph C., 116 New st., New Brunswick
Walker, Robert B., 108 Church st., New Brunsw'k
Walters, George M., 158 Main st., Woodbridge
Wantoch, Joseph, 14 Carteret av., Carteret
Weber, John F., 264 Main st., South Amboy
Weiner, Henry T., 111 Market st., Perth Amboy
Wetterberg, Louis F., 74 Grove av., Woodbridge
White, Harry J., Roosevelt Hospital, Metuchen
**Wiesenfeld, Benjamin, U. S. P. H. S.**
Wilentz, Wm. C., 188 Market st., Perth Amboy
Witmer, John D., 456 Middlesex av., Metuchen

**Number of Active Members and basis of representation. 180.**

### ASSOCIATE MEMBERS

Adler, Lydia, 103 Livingston av., New Brunswick
Cannata, Benjamin, 113 Market st., Perth Amboy
**Forrest, Henry, Army**
Grossman, Walter, 247 Main st., Metuchen
Idelcowitz, Marie, 113 Washington st., SouthRiver
Lind, Zoltan H., Middlesex Gen. Hosp.,NewBruns.
Putter, Eric, 180 N. Main st., Milltown
**Racz, George, Army**
**Van Mater, John S., Navy**
Walker, Otto, 72 Roosevelt av., Carteret
Williams, Henry N., St. Home for Boys, Jamesb'g

### HONORARY MEMBERS

Applegate, Grover T., New Brunswick
Burnett, Charles B., South River
Collins, James J., Woodbridge
Henry, Frank C., Perth Amboy
Lund, John L., Perth Amboy
Spencer, Ira T., Woodbridge
Tyrrell, George W., Perth Amboy
Voorhees, Howard C., New Brunswick

### TRANSFER

Fazio, Vincent J., to Monmouth County

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## MONMOUTH COUNTY (13)

Society organized July 24, 1816. Meets on fourth Wednesday of each month from September to June, inclusive. Annual Meeting in April.

### ACTIVE MEMBERS

Albright, Louis F., 118 Madison av., Spring Lake
**Altschul, Frank J., Army**
Andrews, Thomas H., 111 Main st., Matawan
Baeseman, R. Winfield, 501 Grand av., Asbury P'k
Baker, Elsworth F., N. J. State Hosp., Marlboro
**Bar, Samuel, Army**
Becker, Sidney D., 140 Maple pl., Keyport
Binder, Joseph, 101 Third av., Long Branch
**Blaisdell, C. Byron, Navy**
**Bornstein, Paul K., Army**
Bossone, Joseph E., 172 Garfield av., LongBranch
Boyd, John B., 31 Oakland st., Red Bank
Bregman, Milton, 81 Union av., Manasquan
Brindle, Harry R., 501 Grand av., Asbury Park
Brown, Edith L., 340 Garfield av., Avon
Brown, Kenneth G., 501 Grand av., Asbury Park
Burkhead, Howard C., 177 Garfield av.,LongBr'ch
**Captanian, Aram A., Army**
Carey, David S., 11 E. Main st., Freehold
Carter, Joseph F. S., 142 Atkins av., Asbury Park
**Casagrande, Stephen R., Army**
**Clark, John C., Army**
**Colby, Maxwell X., Army**
**Costa, Philip L., Army**
Daversa, Benjamin, 219 Madison av., Spring Lake
Delcau, Jules, 56 W. Main st., Freehold
dePons, Sarah C., 501 Grand av., Asbury Park
DeVita, Anthony J., Wilson av., Port Monmouth
Dewis, Edwin G., 21 Westra st., Interlaken
Diamond, David I., Oceanport av., Oceanport
Dimitrow, Helen, 161 Broad st., Red Bank
Dorr, Henry B., 87 Washington st., Long Branch
Duvall, Albert I., N. J. State Hospital, Marlboro
**Edelson, Samuel, Army**
Ellenson, Solomon S., 507 4th av., Asbury Park
Fazio, Vincent J., 104 Maple av., Red Bank
**Featherston, Daniel F., Army**
**Feinberg, Harry D., Army**
Feldman, Joel, Rumson rd., Rumson
Feman, J. George, 141 Main st., Keansburg
**Fenton, Tennant E., Army**
Fisher, James A., 501 Grand av., Asbury Park
Freedman, Harold H., 63 W. Main st., Freehold
Gesswein, Carl A., 35 Church st., Matawan
Glazer, Edward, 550 Cookman av., Asbury Park
**Goff, Frank J., Army**
Gordon, J. Berkeley, N. J. State Hosp., Marlboro
**Graves, Charles C., Jr., Navy**
**Haines, Emerson S., Army**
**Halbstein, Bernard M., Army**
**Hancock, Michael Q., Army**
**Hardy, John W., Army**
Hausman, Samuel W., 50 W. Front st., Red Bank
**Heatley, William, Navy**
Herrman, Wm. G., 501 Grand av., Asbury Park
Heymann, Ernest F., 345 Broad st., Red Bank
Hindle, F. Lawton, 145 Maple av., Red Bank
**Hodas, Sidney M., Army**
**Holman, Francis W., Army**
Holters, Otto R., 1002 Emory st., Asbury Park
Ingling, Harry W., 51 W. Main st., Freehold
Jamison, Wm. F., 501 Grand av., Asbury Park
Jones, Granville L., N. J. State Hospital, Marlboro
**Jordan, Joseph C., Army**
**Kazmann, Harold A., Navy**

Knapp, Victor, 505 Second av., Asbury Park
Leonard, Lothair L., 615 Asbury av., Asbury Park
**Levin, Jack, Army**
Lewis, Jacob, 43 Court st., Freehold
**Lorenzo, Michael J., Army**
Lussier, Georges H., N. J. State Hosp., Marlboro
MacKenzie, Robt. A., 501 Grand av., Asbury Park
Maher, John E., 90 3rd av., Long Branch
Makin, John B., 501 Grand av., Asbury Park
Manahan, Daniel V., 55 E. Front st., Red Bank
**Martin, Leonard J., Army**
**Mason, Howard B., Navy**
Matthews, William, 139 Broad st., Red Bank
**McCreight, David W., Army**
**McDonnell, George J., Army**
McKelvie, Julius C., 55 Rockwell av., Long Branch
McTague, Robt. S., 88 3rd av., Atlantic Highlands
Miele, Frank A., 314 Carr av., Keansburg
**Miller, S. Thomas, Army**
**Mohair, John P., Navy**
Mulligan, Edward W., 23 Monmouth st., RedBank
Murphy, Charles M., 21 Main st., Farmingdale
Neiderhoffer, Sydney L., 469 Br'dway, LongBr'nch
Nichols, Stanley H., 517 Broadway, Long Branch
**Niemtzow, Frank, Army**
Osborn, A. Downey, 519 Sixth av., Belmar
Parker, James W., 175 Shrewsbury av., Red Bank
Parry, Oliver K., 601 Bangs av., Asbury Park
**Perrine, Cornelius C., Navy**
**Perrotta, Anthony J., Army**
**Pieper, Howard C., Navy**
Pietri, Raoul, 501 Grand av., Asbury Park
**Pignataro, Frank P., Army**
**Pleasants, Edward N., Army**
Podell, A. Alfred, 51 E. Front st., Red Bank
**Pons, Carlos A., Army**
Pregnall, James P., 501 Grand av., Asbury Park
**Quirk, Martin A., Navy**
**Raffetto, Joseph F., Navy**
**Reynolds, Donald G., Army**
Reynolds, George G., 64 W. Main st., Freehold
Robinson, Ernest A., 149 Atkins av., Asbury Park
Robinson, Wm. A., 62 Main av., Ocean Grove
**Rosenthal, Abraham, Army**
Rubin, Adrian D., 401 1st av., Asbury Park
**Rubin, Harold, Army**
Rullman, Walter A., 58 W. Front st., Red Bank
Sacco, Gregory E., 191 Broad st., Red Bank
Sayre, William D., Box 202, Red Bank
**Schlossbach, Theodore, Navy**
**Schmidt, Albert F., Navy**
Sewell, Stephen, 320 Passaic av., Spring Lake
**Shanik, William, Army**
Slocum, Harry B., 263 Bath av., Long Branch
Stevenson, Geo. S., West Front st., Red Bank
Stewart, Edwin F., 94 Fairhaven rd., Fair Haven
Strahan, Frank G., 473 Broadway, Long Branch
Straughn, Clinton C., 23 Monmouth st., Red Bank
Strauss, Arthur, 130 Pavilion av., Long Branch
Thomas, Harry G., 1113 5th av., Asbury Park
Trippe, Clarence M., 702 Asbury av., Asbury Park
**Trippe, Morton F., Army**
Upham, Helen F., 305 Third av., Asbury Park
Villapiano, Jos. G., 701 Sunset av., Asbury Park
Von Oehsen, Wm. H., 623 4th av., Bradley Beach
**Wainright, Melvin A. R., Army**
Wilbur, Franklin L., 515 Eighth av., Asbury Park
**Wilkins, Stanley O., Army**
Wilson, Robert B., 91 Broad st., Red Bank
Woodruff, Ralph G., Main st., Englishtown
**Woronoff, Murray, Army**
Worthington, Jos. A., 609 4th av., Bradley Beach

**Number of Active Members and basis of representation. 137.**

### ASSOCIATE MEMBERS

Biggar, Raymond W., 268 Broad st., Red Bank
Booth, Herbert W., 401 Ludlow av., Spring Lake
Demaree, Richard H., 301 Norwood av., W.L'gBr'h
Jones, Helen E., 617 Seventh av., Asbury Park

### HONORARY MEMBER

Ransohoff, Nicholas S., Long Branch

### TRANSFERS

Daversa, Benjamin, from New York
Fazio, Vincent J., from Middlesex County

### RESIGNED

Brown, Harvey S.
Scott, Elmer A.

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## MORRIS COUNTY (14)

Society organized June 11, 1816. Meets on the third Thursday in October, December, March and June. Annual Meeting in June.

### ACTIVE MEMBERS

Ackermann, Edward, 5 Richards av., Dover
Alcaro, Joseph A., 16 W. Blackwell st., Dover
**Atkinson, John M., Army**
Baker, Augustus L., 389 W. Blackwell st., Dover
**Ballard, William C., Army**
Beaver, Jennie D., 44 Elm st., Morristown
**Benz, Francis J., Army**
**Bertha, Nicholas A., Army**
Bird, Frank L., Main st., Netcong
Blanchard, Charles L., 28 E. Blackwell st., Dover
**Bobadilla, Juan E. B., Army**
**Booth, William K., Army.**
Bowers, F. Clyde, Mountain av., Mendham
Byrne, J. Arthur, 16 Elm st., Morristown

Cohen, Oscar H., 115 Church st., Boonton
Collins, Laurence M., N.J.State Hosp.,Gr'yst'neP'k
Comeau, Geo. W., 415 Speedwell av., Morris Plns.
Cook, Dora G., 135 Cornelia st., Boonton
Corwin, Emanuel M., Henn Bldg., Denville
Costello, William F., 55 W. Blackwell st., Dover
Coultas, Aldo B., 1 Madison av., Madison
**Crandell, C. Archie, Army**
Crane, Percy R., Aurora Institute, Morristown
Cummins, Ella F., 39 Elm st., Morristown
Curry, Marcus A., N.J. State Hosp.,GreystoneParkPark
**DeFelice, Mario T., Army**
**Deichman, Charles H., Navy**
DeRosa, Louis, Main av., Stirling
**Dochtermann, Warren P., Army**
Dredge, Thomas J., N.J. State Hosp.,GreystonePk.
Earp, Ruth, 15 Olcott av., Bernardsville
Eckhardt, Ralph A., 50 Green Village rd., Madison
**Emory, George B., Jr., Army**
Esposito, Amedo C., N.J. StateHosp.,GreystonePk.
**Evans, Edgar J., Navy**
**Failmezger, Theodore R., Army**
Falvello, Nicholas A., 28 Wetmore av., Morristown
Ferriss, Ruth B., 51 Maple av., Morristown
**Forbes, John S., Jr., Navy**
Frost, Inglis F., 181 South st., Morristown
Gambill, Perry J., N. J. State Hosp.,GreystonePk.
Gantt, Margaret H., 43 Hillcrest rd., Madison
Geary, Daniel J., 40 Maple av., Morristown
**Gebirtig, Theodore, Army**
**Gilbertson, Robert L., Army**
Glazebrook, Francis H., "HoneysuckleW'ds,"Rumson
Gordon, Charles D., Mt. Arlington
Graddick, Lester W., 22 Sussex av., Morristown
Grant, Raymond J., 69 S. Morris st., Dover
Gregory, Marie F., 50 Green Village rd., Madison
Griscom, I. Norwood, 204 Church st., Boonton
Hampton, George R., N.J.StateHosp.,GreystonePk.
**Harrington, J. Henry, Army**
Hatch, Harold S., Shonghum Mt. Sana., Morrist'n
Haven, Samuel C., 14 Elm st., Morristown
**Hiler, Stuart A., Navy**
Hogan, Marshall D., 311 W. Main st., Boonton
Hubert, Antonio O., 131 E. Main st., Rockaway
Johnston, Julian F., 21 Van Doren av., Chatham
Kessler, Edward I., N.J. State Hosp.,Greystone P'k
King, Alden P., 400 W. Blackwell st., Dover
Klein, Milton, 45 E. Blackwell st., Dover
Knowles, Frederick E., 103 Church st., Boonton
Kossmann, Walter J., Long Valley
Krauss, Fletcher I., 407 Main st., Chatham
**Kuite, George B., Army**
Larson, Henry M., 35 Franklin st., Morristown
Lathrope, George H., 965 Broad st., Newark
**Laudig, Guy H., Army**
**Loksa, Harold T., Army**
**Luippold, Eugene J., Jr., Army**
Mathews, Raymond H., 186 South st., Morristown
**McCluskey, Harry B., Army**
McMahon, Bernard C., 15 James st., Morristown
McMurray, Geo. B., N.J. State Hosp.,Gr'yst'ne P'k
McMurtrie, William A., 20 Franklin st., Morrist'n
Melvin, Daniel G., N. J. State Hosp., GreystonePk.
Mills, Clifford, 36 Maple av., Morristown
Monte, Thomas D., 16 Ledgewood av., Netcong
**Musetto, Carmelo A., Navy**
Mutchler, H. Raymond, 153 E. Blackwell st.,Dover
**Navazio, Attilio, Army**
**Nicoll, George L., Navy**
**Palazzo, William L., Army**
**Parry, Allen A., Army**
Parry, Antoinette R., 93 Greenwood av., Madison
Pinckney, Frank H., 186 South st., Morristown
Plume, Clarence A., Main st., Succasunna
**Pollock, Samuel L., Army**
Pottinger, Wm. E., 6 Altamont court, Morristown
Prager, Bert A., 511 Main st., Chatham
Renna, Francis, 20 Morris av., Morristown
Rice, Franklin W., 184 South st., Morristown
**Riley, Philetus H., Army**
**Rosenberg, Alvin A., Army**
**Rubens, Otto, Army**
**Rubin, Samuel, Army**
Ryman, Merlin T., 5 Dunbar st., Chatham
**Saltus, Lloyd S., Army**
Seward, Frederic H., 40 Green Village rd.,Madison
**Shanik, Morton J., Army**
**Sherman, Benjamin, Army**
Sherman, Byron G., 52 Maple av., Morristown
Smith, Malcolm K., 22 Madison av., Morristown
Spencer, Alvan, 395 W. Blackwell st., Dover
**Stage, Earl DeW., Army**
**Talmage, William G., Army**
**Taylor, Malcolm C., Army**
Teller, Daniel W., Jr., 28 DeHart st., Morristown
**Terreri, D. Joseph, Army**
Teskey, Stanley, 10 Anderson rd., Bernardsville
Thomas, Thomas S., Jr., 18 Elm st., Morristown
**Van Sickle, Albert W., Army**
von Deilen, Henry O., 28 DeHart st., Morristown
Voorhies, Wm. S., Jr.,N.J.StateHosp.,GreystonePk.
**Voss, J. Landon, Army**
Wade, Francis A., 196 South st., Morristown
Ward, Albert J., 39 Elm st., Morristown
Washburn, Philip C., Sylvan drive, Morris Plains
Weiss, Herman, Aurora Institute, Morristown
**Williams, David P., Navy**
Williams, Louis E., 80 Green av., Madison
**Woodman, Charles B., Army**
Young, George J., 60 Maple av., Morristown
Zimmerman, Robert F., 28 Wash'gton av.,M'rrist'n
Zuck, John A., Main st., Netcong

**Number of Active Members and basis of representation, 126.**

## HONORARY MEMBERS

Coultas, Aldo B., Madison
Glazebrook, Francis H., Rumson
Hampton, George R., Greystone Park
Haven, Samuel C., Morristown
Knowles, Frederick E., Boonton
Mills, Clifford, Morristown
Plume, Clarence A., Succasunna
Prager, Bert A., Chatham
Seward, Frederic H., Madison

## COURTESY MEMBER

Joy, Homer T., Morristown

## TRANSFER

McMurtrie, William A., from Warren County

## OCEAN COUNTY (15)

Society organized October 28, 1903. Meets on second Wednesday of each month except July and August. Annual Meeting in May.

### ACTIVE MEMBERS

Appleton, Ralph, Lincoln av., Point Pleasant
Bierach, Jules L., Washington st., Toms River
Buermann, Robert, 206 Madison av., Lakewood
Bunnell, Frederick N., 22 S. Main st., Barnegat
Carmona, L. Roberto, 141 Wood st., Tuckerton
Dodd, Wm. E., Ocean st. & Bay av., Beach Haven
**Falkinburg, LeRoy W., Army**
**Frazee, William H., Jr., Army**
**Gaumer, George W., Army**
Goldstein, Abraham, 404 Madison av., Lakewood
Green, Thomas J., New Egypt
Hayden, Walter G., 504 Main st., Toms River
**Henriksen, J. Bruce, Army**
Herbener, Eugene G., 423 Third st., Lakewood
**Hogan, James J., Navy**
**Ivory, Harry S., Navy**
**Joy, Ernest H., Navy**
Lehmacher, Frank, 16 Central av., Lakewood
Menge, Carl H., 236 Washington st., Toms River
**Neiman, Watson E., Army**
**Nyvall, Pierre J., Army**
Obert, J. Edwin, Main st., New Egypt
Pecora, Carmine L., 212 Wash'gton st.,TomsRiver
**Rinzler, Harvey, Army**
Sawyer, Blackwell, 109 Wash'gton st., Toms River
**Schneider, Clinton R., Army**
**Sickel, Emanuel M., Army**
**Smith, Edward C., Army**
**Szold, Norman F., Army**
**Taylor, Raymond A., Army**
**Tilles, Samuel, Army**
Towbin, Adolph, 326 Third st., Lakewood
Witte, C. Norman, 422 River av., Point Pleasant

**Number of Active Members and basis of representation, 33.**

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## PASSAIC COUNTY (16)

Society organized January 14, 1844; Society chartered November 14, 1843. Meets on third Tuesday of each month except June, July, and August. Annual Meeting in May.

### ACTIVE MEMBERS

Ackerhalt, Martin J., 408 Clifton av., Clifton
Allen, Arthur A., 365 Park av., Paterson
**Allen, Edwin J., Army**
**Allen, James M., Navy**
**Alpren, Bernard F., Army**
Andrews, Albert G. K., 75 Tulip st., Passaic
**Apter, Abraham H., Army**
Ash, Frank W., 180 Carroll st., Paterson
Atwood, Edward A., 360 Park av., Paterson
**Averbach, Jacob, Navy**
**Balles, Edward S., Army**
**Barlow, Frank A., Navy**
**Barolsky, Benjamin, Army**
**Barr, Joseph, Army**
Baxt, Sidney J., 544 21st av., Paterson
Becker, Frank F., 298 Diamond Br.av.,Hawthorne
**Becker, George L., Navy**
Becker, Leo V., 69 Ward st., Paterson
Bender, Theodore, 666 Broadway, Paterson
**Benjamin, Joseph F., Navy**
Bergin, Joseph V., 315 Broadway, Paterson
**Berk, M. David, Army**
Berkhout, Peter G., 106 Haledon av., Prosp'ctP'k
Bernson, Samuel T., 33 Bartholf av., PomptonLks.
Beshlian, Hagop K., 7 Lee pl., Paterson
Biczak, Arkad K., 311 Lexington av., Clifton
**Blake, Albert J., Army**
Bohl, Louis J., 320 Broadway, Paterson
Bongiorno, Henry D., 516 River st., Paterson
Bornstein, David, 566 Broadway, Paterson
Botbyl, Burt W., 927 Madison av., Paterson
Boylan, Lawrence B., 630 Main st., Paterson
**Brancone, Alphonse M., Army**
**Brogan, Francis B., Army**
Bromberg, Chas. B., 107 Lexington av., Passaic
Brooks, Sidney S., 380 12th av., Paterson
Budd, J. Reuben, 379 Clifton av., Clifton
Bullen, Victor E., 148 Hamilton av., Paterson
Butterfield, Arey A., 655 Main av., Passaic
Calligaro, Egiido A., 288 Parker av., Clifton
Capell, Harry H., 302 Broadway, Paterson
Capio, Mario D., 293 Broadway, Paterson
Carlisle, John H., 129 Prospect st., Passaic
Carlough, David J., 426 Ellison st., Paterson
Catanzaro, Francesco, 151 Jefferson st., Passaic
**Chapman, Walter I., Navy**
Chapnick, Maurice M., 117 Paterson st., Paterson
**Charney, William, Army**
Cherry, Homer H., Valley View Sana., Paterson
Chester, Saul W., 634 Broadway, Paterson
**Chilton, Forrest S., Navy**
Chrisman, Irving, 423 Broadway, Paterson
**Churg, Jacob, Army**
Ciccone, Anthony C., 389 Grand st., Paterson
**Clark, Orlo H., Navy**
**Close, Byron H., Army**
Cohen, Julian, 592 E. 29th st., Paterson
Cohen, Louis, 257 Paulison av., Passaic
**Cohen, M. Marvin, Army**
Cohn, Isidor, 231 Lexington av., Passaic
**Cole, L. Frank, Navy**
**Connolly, Joseph P., Navy**
**Conserva, Peter V., Navy**
Cortese, Alvin E., 26 Ward st., Paterson
Cotton, Norman T., 219 Graham av., Paterson
Cremens, John F., 144 Carroll st., Paterson
Crescente, Fred J., 827 Madison av., Paterson
Crounse, David R., 84 Broadway, Passaic
Curtis, A. Maurice, 445 Van Houten st., Paterson
Davis, A. Hobson, Paterson Gen. Hosp., Paterson
**Dawson, Harry, Navy**
DeBell, Peter J., 65 Summer st., Passaic
**DeGrace, Francis H., Army**
Deich, Samuel R., 162 Lexington av., Passaic
Delario, Anthony J., 316 Broadway, Paterson
**Del Mauro, Alphonse, Army**
DeMattia, Michael, 71 Ward st., Paterson
**DeRosa, Armand, Army**

Desmet, Victor F., 324 Broadway, Paterson
**De Yeo, Leon E., Navy**
Dingman, Norman M., 330 Broadway, Paterson
**Doktor, David, Army**
**Donnelly, Joseph E., Army**
Douglass, Stephen A., Valley View Sana.,Paterson
**Dow, Robert F., Army**
Drake, Daniel E., Union Valley rd., Newfoundland
Duncan, Owsley B., 654 East 28th st., Paterson
Dunning, Walter L., 533 River st., Paterson
Dwyer, Henry E., 261 Madison st., Passaic
Dwyer, William A., 99 Park av., Paterson
**Edlkraut, Edward C., Army**
Ehrenfeld, Edward, 185 Lexington av., Passaic
Ehrenfeld, Irving, 185 Lexington av., Passaic
Ekings, Frank P., 221 Broadway, Paterson
**Esposito, Anthony L., Army**
Farkas, Gustav, 255 Harrison st., Passaic
Feigenoff, Israel, 271 Park av., Paterson
Fenster, Morton N., 211 Lexington av., Passaic
Fenwick, John R., 196 Lakeview av., Clifton
Ferrary, Paul B., 232 Totowa rd., Totowa
Fielding, William M., 245 Park av., Paterson
**Fiering, Abraham M., Army**
**Fishbein, Elliot, Army**
**Fisher, Samuel, U. S. P. H. S.**
Flitcroft, William, 510 River st., Paterson
**Fortuin, Floyd, Army**
Fraulo, Louis, 310 Crooks av., Clifton
Freedman, Jacob S., 178 Hamilton av., Passaic
Gallardo, Agustin, 61 Lakeside av., Pompton Lks.
**Gallo, James S., Navy**
Garnett, Robert, 204 Madison st., Passaic
**Geiger, Harold C., Army**
**Gelman, Sidney, Army**
Giambra, Sante M., 666 Broadway, Paterson
Ginsburg, Samuel, 227 Paulison av., Passaic
Glasgow, Thomas M., 120 Passaic av., Passaic
Gochman, Harry M., 166 Hamilton av., Paterson
Goldenberg, Raphael R., 588 E. 27th st., Paterson
Golding, Harry N., 180 Carroll st., Paterson
Goldstein, Edward W., 356 Park av., Paterson
**Gordon, Abel, Army**
**Gordon, Samuel, Army**
Gormley, Cyrus M., 15 Kiel av., Butler
Gould, John H., 92 Monte Vista av., Ridgewood
**Graeter, F. Albert, Army**
Graham, Archibald F., 42 Park av., Paterson
Graham, Theodore K., 279 Park av., Paterson
Greengrass, Jacob J., 146 Broadway, Paterson
**Guarraia, Joseph, Army**
**Gurnee, Quinby D., Army**
Hall, Wayne W., 240 Prospect st., Ridgewood
**Halnan, John J., Jr., Army**
Hambright, Arthur M., Wyckoff av., Ramsey
Harreys, Chas. W., 153 Prospect st., Ridgewood
Hatem, Elias J., 1046 Main st., Paterson
**Hayman, Irving R., Army**
**Hillmann, Frederick C., Army**
Hirsch, Samuel, 118 Lexington av., Passaic
Hollingsworth, H. Hale, 86 First st., Clifton
Holmes, Thomas J. E., 151 Fair st., Paterson
**Holster, Stephen G., Navy**
Holt, Herman H., 576 Broadway, Paterson
Hughes, J. Vernon, P. O. Box 454, Passaic
**Ianaconc, John A., Army**
**Iraggi, James V., Army**
Izenberg, David, 555 E. 29th st., Paterson
Jaffe, Hyman, 149 Broadway, Passaic
Jahn, Albert G., 657 Main av., Passaic
Jani, Frank F., 297 Lexington av., Passaic
Jarmulowsky, Harry, 181 E. 33rd st., Paterson
**Jehl, Joseph R., Army**
Joelson, Dora, 485 Park av., Paterson
Joelson, Morris S., 577 Broadway, Paterson
**Joffe, Philip M., Army**
**Joffe, Sidney H., Army**
Johnsen, Sigurd W., 149 Prospect st., Passaic
Joseph, Morris, 271 Lexington av., Passaic
Katz, Harry, 494 Park av., Paterson
Katz, Herbert I., 278 Park av., Paterson
Keating, Charles A., 177 Ellison st., Paterson
**Keating, Joseph M., Army**
**Keller, Michael L., Army**
**Kennedy, A. Andrew, Navy**
Kennedy, Eugene T., 413 Wanaque av.,Pmptn.Lks
Keppler, Charles, Jr., 723 Allwood rd., Clifton
Kim, Gay B., 703 Main st., Paterson
Kinney, Burton O., 41 Lincoln av., Little Falls
Kleiner, Samuel, 162 Hamilton av., Paterson
Kleinmann, Eberhart H., 560 Broadway, Paterson
Klughaupt, Dorothy K., 49 Passaic av., Passaic
Koenig, Bertram, 311 Broadway, Paterson
**Koerber, George, Army**
Kovaleski, Walter A., 77 Market st., Passaic
Kovin, Abraham, 123 Lexington av., Passaic
**Krieger, George, Army**
**Laauwe, Harold W., Navy**
Landaw, Louis, 631 E. 26th st., Paterson
Lawrence, Arthur C., Main st., Lincoln Park
Lawrence, Elias D., 428 Park av., Paterson
**Leach, John E., Army**
Lee, Frederick P., 606 E. 27th st., Paterson
Leibovitz, Altan C., 261 Lexington av., Passaic
**Lemay, Albert T., Navy**
**Levendusky, Daniel E., Army**
LeVine, Israel, 215 Broadway, Paterson
Levine, Sidney C., 459 Park av., Paterson
Levinsohn, Sandor A., 656 East 29th st., Paterson
Levy, David, 265 Park av., Paterson
Levy, Herman, 219 Lexington av., Passaic
**Liana, Stephen M., Army**
Lima, John G., 292 Broadway, Paterson
Linares, A. Carfi, 208 Market st., Paterson
**Lipton, Louis, Army**
Lobsenz, Nathan P., 294 Broadway, Paterson
Lomauro, James R., 184 Lexington av., Passaic
London, Jules R., 340 Paulison av., Passaic
Low, Donald B., 529 Broadway, Paterson
Lucent, S. Bell, 2 First av., Little Falls
Luksteid, Casimir J., 326 Park av., Paterson
MacAlister, Wm. W., 171 Carroll st., Paterson
MacGregor, Allan W., 379 Ellison st., Paterson
MacGuffie, Robert N., 657 Main av., Passaic
Mackler, Meyer E., 627 E. 24th st., Paterson
Maclay, Joseph A., 239 Broadway, Paterson
Maffongelli, Joseph A., 494 River st., Paterson
**Magnes, Max, Army**
Manly, Thomas E., 390 Park av., Paterson
Manzione, Frank A., 500 Union av., Paterson
Maps, Howard L., Country Club Estates, Budd Lk.
Marini, Dominick, 40 Henry st., Passaic
**Markel, Albert G., Navy**
Markowitz, Louis, 380 Park av., Paterson
**Marrocco, William A., Army**
**Martin, Theodore, Army**
Masucci, Alberico, 128 Carroll st., Paterson
Matthews, Leonard M., 655 Main av., Passaic
Mazzarella, Carlo, 237 Broadway, Paterson
McBride, Andrew F., 30 Church st., Paterson
**McBride, Andrew F., Jr., Army**
**McCarthy, George L., Navy**
McCue, John B., 118 Lenox av., Pompton Lakes
McDonald, Richard J., 80 Park av., Paterson
**McPherson, Malcolm E., Army**
Meier, William U., 1062 Ringwood av., Haskell
Meloney, Lester F., 156 Second st., Clifton
Meneve, Alfred D., 373 Broadway, Paterson
**Meyers, Francis R., Navy**
**Michelson, Henry, Army**

Missonellie, Wm., 404 Lafayette av., Hawthorne
Mitchell, Charles R., 311 Broadway, Paterson
**Monaloy, Morris A., Army**
Morici, Theodore, 80 Howe av., Passaic
**Morrill, James P., Jr., Army**
Moscoe, Harry A., 951 Madison av., Paterson
**Mott, Joseph E., Navy**
Murn, Charles J., 48 Smith st., Paterson
Neer, William, 308 Woodside av., Ridgewood
Nemirow, Martin, 234 Lexington av., Passaic
Nesbitt, Elizabeth, No. Jersey Tr'n'gSch'l,LittleFalls
Norval, William A., 419 Main st., Paterson
**Notkin, Meyer, Army**
Noto, Philip, 158 Washington pl., Passaic
Nye, Howard H., 174 Carroll st., Paterson
O'Brian, Dennis M., 154 Lexington av., Passaic
O'Brian, Jeremiah H., 204 Madison av., Passaic
Ogden, Michael A., Passaic General Hosp., Passaic
Okin, Irving, 165 Passaic av., Passaic
**Opper, Philip, Army**
Oram, Joseph H., 495 Broadway, Paterson
**Palma, Nicholas, Navy**
Palmer, Francis R., 220 Lexington av., Passaic
**Paris, William, Army**
**Pasternack, Elroy, Army**
Patella, Fulvio, 324 Broadway, Paterson
**Pernetti, Anthony M., Army**
Phelps, James E., 203 Park av., Paterson
**Piasecki, Chester A., Army**
Piller, Jacob, 213 Broadway, Paterson
**Pink, Solomon H., Army**
Plinke, Fritz W., 265 Gregory av., Passaic
Polizzotti, Joseph L., 193 Park av., Paterson
**Pollock, Theodore, Army**
Polowe, David, 555 E. 27th st., Paterson
**Prince, Robert A., Navy**
Provisor, Benjamin, 271 Lexington av., Passaic
**Raab, Michael, Army**
Radest, Louis J., 347 Broadway, Paterson
Randazzo, Anton P., 82 Prospect st., Passaic
**Rauschenbach, Paul E., Jr., Army**
Reading, H. Eugene, 535 E. 29th st., Paterson
Reeves, Ernest, 195 Lexington av., Passaic
**Reilly, Thomas F., Army**
**Reiner, David M., Army**
**Reinhorn, Abraham J., Army**
Riccobono, Cosmo S., 334 Park av., Paterson
Rinzler, Harry G., 127 Van Houten av., Passaic
Ritter, John J., Box 86, Plainfield, Mass.
**Robertson, Eugene V., Army**
Roemer, Jacob, 591 E. 27th st., Paterson
**Romano, Michael J., Army**
**Ross, Peter W., Army**
Roy, Joseph N., 95 17th av., Paterson
RuBacky, Joseph F. A., 61 Passaic av., Passaic
**Ruocco, William B., Navy**
Russell, Charles B., 119 Hamilton av., Paterson
Sabarese, Theodore C., 122 Marsellus pl., Garfield
**Saffron, Morris H., Army**
Sala, Aldo W., 172 Randolph av., Clifton
Salter, Kent, Valley View Sana., Paterson
Salzman, Nathan, 714 Broadway, Paterson
Sanfacon, Thomas A., 340 Park av., Paterson
Sarokhan, Joseph, 771 Madison av., Paterson
**Santangelo, Emil L., Army**
Schafer, Marguerite A., 298D'mondBr. av.,H'wth'rne
Schefrin, Alexander E., 235 Lexington av., Passaic
Schlossberg, Ezra, 175 Broadway, Passaic
Schultz, Augustin M., 379 Union av., Paterson
**Schwartz, Jacob R., Army**
Schwartz, William, 224 Lexington av., Passaic
**Schwartzberg, Frederick I., Army**
Schwarz, Julianna L., 22 VanWinkle av., Passaic
**Scielzo, Nicholas F., Army**
Scribner, Chas. H., R.F.D.1, Hamb'gTnpk.,Pat'rs'n
Shapiro, David, 707 Broadway, Paterson
Shapiro, Louis G., 375 Broadway, Paterson
Shechtman, Abraham, 261 Main av., Passaic
Sheft, Matthew J., 112 Lexington av., Passaic
Shinefeld, Maurice A., 669 Broadway, Paterson
Shipman, Meyer P., 575 Broadway, Paterson
Shippee, James N., 648 Ringwood av., Wanaque
**Schubert, Roy R., Navy**
Shulman, Abraham, 528 E. 29th st., Paterson
Silverman, Irving A., 260 Dayton av., Clifton
Simkin, Abraham, 232 Broadway, Passaic
**Simon, Julius J., Army**
Simon, Philip H., 174 Columbia av., Passaic
Slaff, Florence, 16 Grove st., Passaic
Sloan, Samuel L., 182 Belmont av., Paterson
**Small, Louis, Army**
Smith, Elroy W., 309 E.DeLido dr.,MiamiBch.,Fla.
Smith, Leon A., 655 Main av., Passaic
Sobel, I. Jerome, 136 Broadway, Passaic
Spickers, William, 6 Church st., Paterson
Stark, Jacob, 645 Broadway, Paterson
Stein, Harold M., 227 W. Broadway, Paterson
**Steinberg, Benjamin L., Army**
**Stern, Morris H., Army**
Stoltz, Raymond R., 23 Passaic av., Passaic
**Stouter, Francis L., Army**
Sucoff, Moses C., 158 Hamilton av., Passaic
Sullivan, William M., Jr., 43 Passaic av., Passaic
Surgent, George W., 168 Clifton av., Clifton
**Sutherland, William W., Army**
Szymanski, John J., 616 Main av., Passaic
Taber, Leslie R., 292 Broadway, Paterson
**Teichholz, Max H., Army**
**Tell, M. Edward, Navy**
**Thomas, Irene O., Navy**
**Thomas, Leon H. S., Army**
**Thompson, Edward C., Army**
Thorne, William P., 254 Main st., Butler
**Thron, Leopold E., Army**
Todd, Francis H., 83 Auburn st., Paterson
Tomkins, Wm., 105 Fairmount road, Ridgewood
Tweddel, George K., 239 Broadway, Paterson
Udinsky, Hyman J., 21 Grove st., Passaic
**Vanderbeck, James J., Army**
Vanderbeek, Andrew B., 174 Broadway, Paterson
**Vanderbeek, Frank B., Army**
Vander Clock, Cornelius, 178 Gregory av., Passaic
Van Eerde, Albert, 339 Lafayette av., Hawthorne
Van Schott, Gerard J., Jr.,245 Lex'gton av.,Passaic
Van Winkle, John S., 297 Broadway, Paterson
Vermeulen, Abram, 344 Haledon av., ProspectP'k
Vernaglia, Anthony P., 145 B'naVista av.,H'wth'e
**Visceglia, Frank R., Army**
Vosburgh, Fred, 53 Passaic av., Passaic
Vreeland, Ralph J., 266 Van Houten st., Paterson
**Walker, Harold G., Navy**
Wallace, Marc J., 165 Lakeview av., Clifton
Walton, Gordon G., 17 Church st., Paterson
**Warburton, Jack C., Army**
Ward, Albert H., 404 Totowa av., Paterson
Warren, David E., 233 Gregory av., Passaic
Warren, Earl L., 266 Van Houten st., Paterson
Warren, Jacob, 308 18th av., Paterson
Wassing, Hans, 695 Broadway, Paterson
Weinert, Henry V., 128 Market st., Passaic
Weintraub, Wm. L., 400 Broadway, Paterson
**Weisman, Stephen L., Army**
**Westerhoff, Peter D., Army**
**Wethers, William A., Army**
**White, Richard E., Army**
Williams, Hiram, 230 Lexington av., Passaic
Winters, Walter M., 288 Broadway, Paterson
Wishnack, Meyer, 318 Broadway, Paterson
Wolf, Erich, 158 Broadway, Passaic
Wolf, Israel J., 231 East 31st st., Paterson

**Wolfson, Harry, Navy**
Wry, Dean A., 234 Dayton av., Clifton
**Yachnin, Samuel C., Army**
**Yager, J. Allen, Navy**
Yates, John S., 414 Ellison st., Paterson
Yeaw, Ralph C., 180 Carroll st., Paterson
Yolken, Harry, 246 E. 31st st., Paterson
Zalewski, Irene J., 181 Paulison av., Passaic
Zick, Clara U., 60 Highland rd., Glen Rock
Zuckerman, David E., 568 Broadway, Paterson

**Number of Active Members and basis of representation, 388.**

### ASSOCIATE MEMBERS

Achtentuch, Herman, 113 Sherman st., Passaic
Adler, Fritz F., 162 Trenton av., Paterson
Bronner, Alfred, 95 Jackson st., Passaic
**Chudzik, Edward W., Army**
**Feliciano, Vincent, Army**
Fortay, Steven O., 474 Park av., Paterson
Friedman, Edna C., 584 Broadway, Paterson
Gellman, William B., 328 Windsor rd., Woodridge
Gershenson, Wilbur M., 78 Hillman dr.,E.Paters'n
**Goldman, Sol B., Navy**
**Kaletkowski, Marion F., Army**
**Korman, Arnold, Navy**
**Lang, Richard E., Navy**
MacGahan, Wm. H., 516 Wanaque av.,Pmptn.Lks.
**Nussbaum, Nathan, Army**
**Rogers, James A., Navy**
Saco, Louis S., 922 Main st., Paterson
**Scovern, Louis, Army**
Stein, Harriet N., 620 Ridge rd., Lyndhurst
**Tarta, Ciro S., Army**
Yoskowitz, Benjamin, Army

### COURTESY MEMBERS

**Della Penna, Samuel J., Army**
**Pearlman, Saul J., Army**
**Trilling, Leonard J., Army**

### HONORARY MEMBERS

Bergin, Joseph V., Paterson
Bullen, Victor E., Paterson
Crounse, David R., Passaic
Duncan, Owsley B., Paterson
Dunning, Walter L., Paterson
Flitcroft, William, Paterson
MacAlister, William W., Paterson
Maclay, Joseph A., Paterson
McBridge, Andrew F., Paterson
Neer, William, Ridgewood
Norval, William A., Paterson
Ritter, John J., Plainfield, Mass
Scribner, Charles H., Paterson
Todd, Francis H., Paterson
Vanderbeek, Andrew B., Paterson

### TRANSFERS

Bonynge, Henry A., to Virginia
Richards, Paul S., to California
Rothman, Theodore, to California
Van Urk, Frederick T., to Pennsylvania

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## SALEM COUNTY (17)

Society organized May 4, 1880. Meets on the third Friday of each month, September to May, inclusive. Annual Meeting in April. Social Meeting in May.

### ACTIVE MEMBERS

Bramble, Halsey S., Front & Chestnut sts., Elmer
Caggiano, John D., 165 W. Main st., Penns Grove
Chesler, Maurice, 124 W. Broadway, Salem
**Cox, J. Robert, Army**
**Davison, C. Spencer, Navy**
Davison, Wilbur S., 13 N. Broadway, Pennsville
**Dunn, John S., Navy**
Evans, Edgar E., 12 Ziegler Tract, Penns Grove
Fleming, Charles L., 42 W. Main st., Penns Grove
Green, David W., 69 Market st., Salem
Hilliard, William T., 105 Market st., Salem
**Hummel, Lee C., Navy**
Jirouch, Edwin A., 18 Ziegler Tract, Penns Grove
Jonas, August, 328 E. Broadway, Salem
Lipkin, Isadore, 157 W. Main st., Penns Grove
Lummis, Clarence P., 40 Delaware av., Penns Gr.
Mackes, Claude B., 48 N. Main st., Woodstown
Mason, Alvin S., 26 Olive st., Salem
Miller, Lewis H., 37 S. Main st., Woodstown
**Miller, William H., Army**
**Parker, Albert F., Army**
**Perry, Frank L., Army**
Prigger, Edward R., 21 Delaware av., Penns Gr.
Savage, Charles L., 20 Ziegler Tract, Penns Grove
**Sayers, Francis P., Army**
Silverman, R. Louis, 21 W. Main st., Penns Grove
Suter, Harry F., 49 W. Main st., Penns Grove
Thomas, Claude W., 28 East av., Woodstown
Zappala, John, 47 W. Main st., Penns Grove

**Number of Active Members and basis of representation, 29.**

## SOMERSET COUNTY (18)

Society organized May 21, 1816. Meets on second Thursday evening of each month except July, August and September. Annual Meeting in June. Dinner Meeting in October.

### ACTIVE MEMBERS

Adams, Rayford K., Lakeside Lodge, Skillman
Albrecht, William J., 46 Grove st., Somerville
Allegrante, Anthony J., W'sh'gt'nVal.rd.,Martinsville
Ambrose, Robert R., Navy
**Barbour, George E., Army**
**Blank, Samuel, Army**
Borow, Benjamin, 507 Church st., Bound Brook
Borow, Henry, 507 Church st., Bound Brook
**Borow, Louis S., Army**
Borow, Maurice, 507 Church st., Bound Brook
Brittain, Ellmore G., 4 E. High st., Bound Brook
**Cooley, Justus H., II, Army**
Craig, Henry A., 315 William st., Somerville
**Crawford, John W., Army**
**Day, Hayward F., Army**
Douglass, William C., 15 Olcott av., Bernardsville
Edelberg, Sidney S., 403 E. High st., Bound Brook
Ely, Lancelot, 128 W. High st., Somerville
**Falcone, Nicholas A., Army**
Field, Frank L., Far Hills
Flint, Edgar T., 44 E. Somerset st., Raritan
Fritts, Lewis C., 118 West End av., Somerville
Galgoczy, Julius, Manville
Gentile, Ernest R., 653 Lincoln av., PomptonLks.
Glass, George A., 15 W. 11th st., New York, N. Y.
Gray, W. Burritt, 121 Somerset st., N. Plainfield
**Greenberg, George A., Army**
**Guertin, Diomede, Army**
**Heaton, Stuart C., Navy**
Hegeman, Runkle F., 161 W. High st., Somerville
**Heminway, Norman L., Army**
Hird, Emerson F., 118 E. Maple av., Bound Brook
Hochheimer, Arthur, 417 Somerset st., BoundBr'k
Husted, Samuel H., Neshanic Station
Hyer, Godfrey S., W. High st.&Mtn.ave.,S'm'rville
Kay, Clarence R., Main st., Peapack
**Klompus, Irving, Navy**
Knight, Augustus S., Far Hills
**Lawton, A. Anderson, Coast Guard**
Levy, Abram, 1120 W. 7th st., Plainfield
**Liddell, Raymond N., Army**
**Loeb, William A., Army**
Mangelsdorff, Arthur F., W'h'gt'nVal.rd.,M'rt'sv'le
Marcus, Bernard, Garden Apts., Bound Brook
McParland, Timothy W., 1314 Putnam av., Pl'nf'd
Misko, Albert, 117 Westervelt av., N. Plainfield
**Morris, Nathan, Army**
Pearson, Theodore A., White House
Pigott, Albert W., N. J. State Village, Skillman
Pitman, Mason W. H., 17 W. Cliff st., Somerville
Pogoloff, Samuel H., 68 N. 1st av., Manville
Reale, Nicholas P., Brooks Blvd., Manville
Renner, Clara C., Blawenburg
Rossi, Bartolomeo, 325 Vosseler av., Bound Brook
**Rossi, Gene, Army**
Russo, Dominic T., 51 E. Somerset st., Raritan
Sargent, Eva R., 121 Myrtle av., North Plainfield
**Schram, William S., Army**
**Spaldo, John L., Army**
**Thornton, P. John S., Army**
**Tolomeo, Martin E., Army**
**Wallach, Bernard, Army**
**Wolfram, Julius, Army**
Young, James L., 68 Mountain av., Somerville

**Number of Active Members and basis of representation, 64.**

### HONORARY MEMBERS

McConaughy, Francis, Ridgewood
Snyder, Howard P., St. Thomas, Virgin Islands

### TRANSFER

Rossi, Bartolomeo, from Essex County

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## SUSSEX COUNTY (19)

Society organized August 22, 1829. Regular meetings in February, May, September and December at time, place and date designated by President and Secretary.

### ACTIVE MEMBERS

**Aitken, Herbert M., Navy**
**Bergmann, Ewald H., Army**
Boyd, William B., Jr., N. J. Zinc Co., Franklin
**Braun, David C., Army**
Burn, Victor E., 27 Trinity st., Newton
**Caleca, Jack J., Army**
**Cartisser, Joseph J., Army**
Coleman, Joseph G., Hamburg
Drake, Leo B., 47 Main st., Franklin
**Eddy, Lester R., Navy**
**Groeschel, August H., Army**
**Hawke, Edward K., Army**
**Hill, Dean F., Navy**
Johnson, George F., Branchville
Kirschner, Martin I., Vernon
Landes, Edwin W., Stillwater
Longnecker, John E., Jr., Sparta
Lushear, Frank H., Branchville
**McCall, Jesse, Army**
McVeigh, Charles J. D., Netcong
Morrison, Frederick H., 61 High st., Newton
Pellet, Thomas L., Hamburg
Roy, Bert W., 25 Hamburg av., Sussex
Schmidt, Clifford M., 81 Main st., Newton
Scott, Frederick J., 1 Oak st., Franklin
**Spencer, James H., Jr., Army**
Spurgeon, Dorsett L., 19 Church st., Newton
Stewart, Katherine E., Railroad av., Ogdensburg
Vermes, Leslie, 172 Main st., Franklin
Weinstein, Robert A., 214 Spring st., Newton
Weiser, Edward H., 40 Bank st., Sussex

**Number of Active Members and basis of representation, 31.**

# UNION COUNTY (20)

Society organized June 7, 1869. Meets on second Wednesday of September, November, January, March, April, and May Annual Meeting in April.

## ACTIVE MEMBERS

**Abel, Henri E., Army**
**Abramson, Solomon, Army**
Ackerman, Arthur F., 129 Summit av., Summit
**Allen, Samuel L., Army**
Alture, Siegmund S., 1809 N. Wood av., Roselle
**Anson, Leon J., Army**
Apfelbaum, Frederick M., 917 W. 7th st., Plainf'd
Armstrong, Lorrimer B., 121 S. Euclid av., W'stf'd
Arthur, Frances H., 138 Westfield av., Elizabeth
**Austin, Thomas R., Army**
**Babbitt, Hugh M., Jr., Army**
Baker, Raymond D., 52 De Forest av., Summit
Banker, George T., 1145 E. Jersey st., Elizabeth
Barberio, A. Arthur, 1337 Orange av., Union
Baron, Leo E., 26 Prospect pl., N. Plainfield
Baruch, Hilde, 202 Stiles st., Elizabeth
**Baruch, Rudolf J., Army**
**Battaglia, Richard S., Army**
Bechet, Paul E., 1364 North av., Elizabeth
Beisler, Lawrence G., 1528 N. Broad st., Hillside
Bender, Dorothea A., 61 DeHart pl., Elizabeth
Bensley, Maynard G., 129 Summit av., Summit
**Berenson, Samuel J., Army**
Berman, Leonard M., 128 Summit av., Summit
**Berman, Sol, Army**
**Bernstein, Benedict J., Army**
Berry, C. Hartley, 129 Summit av., Summit
Biber, David, 2066 Emerson av., Union
Birrell, Russell G., 554 Westminster av., Elizabeth
Bishop, Carl, 831 Madison av., Plainfield
**Black, Max S., Army**
Blair, Thomas D., 414 Park av., Plainfield
**Blatt, David, Army**
Bloch, Harry, 613 N. Broad st., Elizabeth
Blumberg, Jack, 504 Westminster av., Elizabeth
Blythe, Rowland P., 30 Springfield av., Cranford
**Bolanowski, Kasimier J., Army**
**Booth, Walter S., Navy**
**Bourns, Edward G., Army**
Bowles, Harry H., 36 Woodland av., Summit
**Boyd, Robert P., Army**
**Boyer, Paul K., Navy**
Boyes, James G., 1326 Chetwynd av., Plainfield
**Braun, Edgar M., Army**
Braunwarth, Robert J., 555 S. Broad st., Elizab'th
**Breslow, Alexander E., Army**
Brethwaite, Samuel H., Jr., 129 Summit av., Sum't
Brokaw, Christopher A., 1405 North av., Elizab'th
Brown, Frank H., Jr., 327 Chestnut st., R'sle Park
Brown, L. Greeley, 173 Madison av., Elizabeth
Brown, William H., 501 1st av., Elizabeth
Buchanan, Robert W., 129 Summit av., Summit
**Buffey, Walter H., Army**
Burritt, Norman W., 30 Beechwood rd., Summit
**Butenas, Joseph J., Army**
**Callahan, Edward J., U. S. P. H. S.**
Cannis, John P., 1019 Park av., Plainfield
Canright, Cyril M., 34 Springfield av., Cranford
Cantini, Raphael S., 147 E. 7th st., Plainfield
Card, Charles F., 144 W. Milton av., Rahway
Cardinale, Pasquale F., 654 E. Jersey st., Elizab'h
Carlisle, J. Mallory, 550 Hillcrest av., Westfield
**Carpenter, Cedric C., Navy**
**Carsley, Sidney H., Army**
Casey, Robert B., 104 W. Milton av., Rahway
Casilli, Arturo R., 618 Newark av., Elizabeth
Castaldo, Neil, 103 Lincoln av., E., Cranford
**Chaiken, Louis H., Army**
Chapman, Otis P., 125 Broad st., Elizabeth
Childers, Robert J., 604 Park av., Plainfield
**Chodosh, Maurice A., Army**
Cohen, Harry X., 1243 Stuyvesant av., Union
Cole, Walter H., Jr., 1060 E. Jersey st., Elizabeth
Comunale, Anthony R., 1709 Irving st., Rahway
**Conway, James V., Army**
Coplin, George J., 528 E. Jersey st., Elizabeth
Corbusier, Harold D., Box 868, Sante Fe, N. M.
**Cox, William T. R., Army**
Crabtree, Loren H., 505 Jersey av., Elizabeth
**Crane, Norman T., Army**
**Cronin, Francis J., Army**
Davidson, E. Norwell, 102 East Elm st., Linden
Davidson, Maurice M., 128 Grant av., E., Roselle Pk.
Davis, F. Cleveland, 129 Summit av., Summit
Davis, Stanton H., 212 E. 7th st., Plainfield
Day, Willis B., 407 E. 7th st., Plainfield
DeCesare, Ferdinand J., 500 Walnut st., Roselle P'k
Decker, Charles T., 275 Orchard st., Westfield
**Demarest, Gerald B., Army**
Dengler, Henry P., 260 Morris av., Springfield
**Deutsch, Nathan S., Army**
Diamond, J. George, 512 W. Front st., Plainfield
Doggett, E. Hugh, 805 Park av., Plainfield
Dolsky, Irving, 509 N. Wood av., Linden
duBusc, L. C. Victor, 399 Westfield av., Elizabeth
**Dunn, H. Irving, Army**
Dupuy, Jean G., 525 Court st., Elizabeth
Durrah, Fred F., 310 Plainfield av., Plainfield
**Dwoyer, Leon C., Army**
Eadie, Gordon, 11 Blackburn rd., Summit
Eason, Samuel W., 48 De Forest av., Summit
Edgar, Malcolm S., 129 Summit av., Summit
**Ehrlich, Max, Army**
**Esty, Geoffrey W., Army**
Evans, Joseph O., 727 N. Wood av., Linden
Falconer-Slater, Kath., Four Winds, Katonah, N.Y.
Feleppa, Edward E., 618 Springfield av., Summit
Fiedler, Michael J., 247 Crawford ter., Union
**Fink, Stanley J., Army**
**Fitch, Thomas S. P., Navy**
Fort, William B., 147 E. 7th st., Plainfield
Foster, Frank L., 320 Springfield av., Cranford
Franklin, Joseph E., 191 North av., Hillside
Franklin, Lewis J., 149 Jean ter., Union
**Freeman, Ray M., Army**
Friedburg, George H., 1108 Anna st., Elizabeth
Frohwein, Ida H., 125 Morristown rd., Elizabeth
**Gadomski, Casimir F., Army**
Gallaway, George E., 163 W. Milton av., Rahway
**Gannon, Joseph M., Army**
Geary, Paul, 909 Park av., Plainfield
Gelber, Isaac, 2052 Morris av., Union
Gerendasy, Julius, 956 E. Jersey st., Elizabeth
Gibb, Alice S., 339 Union av., Elizabeth
**Giglio, Alphonsus S. V., Army**
**Gilpin, Fletcher, Army**
**Gittelman, Morton, Army**
Glaser, Emanuel, 360 Linden av., Elizabeth
Glass, Benjamin E., 609 Watchung av., Plainfield
**Glass, Harry L., Army**
**Glassner, Frank, Navy**
Glasston, Hyman M., 628 N. Wood av., Linden
**Golden, William M., Army**
Goldfield, Harold H., 225 E. Jersey st., Elizabeth
Goldmacher, Herman B., 113 Elmora av., Elizab'h
Goldstein, Herman H., 318 W. Jersey st., Elizab'h

**Gonczy, Edward J., Army**
**Grant, William E., Army**
Greenberg, Max, 29 W. Henry st., Linden
Griesemer, Z. Lawrence, 1145 E. Jersey st.,Eliz'h
**Griswold, Merton L., Jr., Army**
Guidi, Guido M., 212 Christine st., Elizabeth
**Hall, Winthrop H., Navy**
Hallock, Wilton J., 650 Springfield av., Summit
**Hamley, John J., Army**
Hansen, Harry, 916 Park av., Plainfield
Hanson, Carl G., 38 Springfield av., Cranford
Herrington, Lee R., 643 E. Broad st., Westfield
Hipple, Percy L., 118 E. 5th av., Roselle
**Hnat, Frederick, Army**
**Hoffman, Charles A., Army**
Holland, Reuben J., 1026 Chandler av., Linden
Holmes, Grace A., 1077 E. Jersey st., Elizabeth
Holtzman, Michael, 167 2nd st., Elizabeth
Horoschak, Anne, 974 Park av., Plainfield
Horre, George W. H., 203 W. Jersey st., Elizabeth
Hubbard, Harry V., 121 E. 7th st., Plainfield
Hughes, Frederic J., 706 Park av., Plainfield
Humphrey, Hubert G., 430 Downer st., Westfield
Hunt, Thomas F., 528 Monroe av., Elizabeth
Hutton, Frederick T., 726 Watchung av., Plainf'd
**Imbleau, Joseph E. L., Navy**
**Jacobs, Alan L., Navy**
Johnson, Harold F., 734 Park av., Plainfield
**Jones, Herbert E., Navy**
**Kaplan, Samuel D., Army**
Kapp, Carl G., 440 Westminster av., Elizabeth
Karnasiewicz, Francis I., 348 Pine av., Garwood
**Karshmer, Ernest E., Army**
Katz, Theodore, 927 S. Wood av., Linden
Keeney, Cadwell B., 137 Summit av., Summit
Kemeny, George, 39 Third st., Elizabeth
Keil, Sigmund S., 1118 St. George av., E., Linden
**Kibbe, Milton H., Army**
Kidd, Ruth W., 2013 Morris av., Union
Knauer, George, 930 Elizabeth av., Elizabeth
Konzelman, Henry J., 65 King st., Hillside
Kramer, Douglas W., 1019 Park av., Plainfield
**Krans, DeHart, Army**
Krans, Edward S., 920 Park av., Plainfield
**Kreutz, Paul J., Army**
Kuchlewski, Edward J., 224 E. Jersey st., Elizab'h
**Kushner, Alexander, Army**
**Kwint, Joseph A., Army**
Kyle, Ernest I., 205 W. 9th st., Plainfield
Labow, Joseph J., 757 N. Broad st., Elizabeth
Ladas, George, 305 Cherry st., Elizabeth
**Lance, Elton W., Army**
Lang, Louis, 947 E. Jersey st., Elizabeth
Langston, Junius T., 521 E. 2nd st., Plainfield
Larrabee, Callie H., 24 Hobart av., Summit
Lathrop, Frederic W., 909 Park av., Plainfield
**Laurie, Andrew L., Army**
Lawrence, Wm. H., 129 Summit av., Summit
Leggett, Lindley H., Jr., 330 E. Broad st.,Westfield
Leggett, Thomas H., Jr., 706 Park av.,Plainfield
**Lepree, Joseph A., U.S.P.H.S.**
Lerman, Irving, 1024 E. Jersey st., Elizabeth
**Lerman, Samuel, Navy**
Lewis, Albert, 41 Retford av., Cranford
Lieberman, David P., 597 Westminster av., Eliz'h
**Lieberman, Milton L., Army**
Lilien, Milton M., 152 Clark st., Hillside
Linke, James J. P., 245 E. Front st., Plainfield
Lippincott, Lansing Y., 939 Park av., Plainfield
Livengood, Horace R., 587 Westm'ster av.,Elizab'h
Llull, Gabriel J., 266 Morris av., Springfield
Losada, Camella A., 19 Prospect st., Summit
Lowell, Milton E., 434 Summit av., Westfield
**Lowenstein, Ernest C., Army**
Ludlum, Walter D., 132 S. Euclid av., Westfield
Lufburrow, Chas. B., 441 W. Front st., Plainfield
**Lyerly, James M., Army**
**Lynch, Edward T., Navy**
**Lynch, Michael F., Army**
**MacBrayer, Reuben A., Army**
MacDonald, Edward O., 719 Locust st., RoselleP'k
Mackler, Harry S., 410 Elmora av., Elizabeth
**Maggio, Ross J., Army**
Malatesta, Chas. S., 1203 Martine av., Plainfield
Mallison, Herbert, 819 Park av., Plainfield
Marone, Carmine R., 752 Newark av., Elizabeth
**Maroney, James H., Navy**
**Marts, George H., Navy**
**Mastroianni, Frank M., Army**
Maurer, Martha E., 519 Lennox av., Westfield
**McAlpine, Paul, Army**
McCallion, Wm. H., 722 Westminster av., Elizab'h
McClintock, Elsie, 1439 Maple av., Hillside
**McGeary, John A., Army**
McGinn, Wm. J., 1913 Westfield av., Scotch Plains
Meeker, John L., 6 De Barry pl., Summit
Meineke, Wm. C., Jr., 818 Chestnut st., Roselle
**Mensch, Harvey G., Army**
Merlo, Francis A., 210 Murray st., Elizabeth
**Merlo, Francis V., Army**
Milligan, Robert S., 42 Elm st., Summit
Milliser, Estelle T., 505 E. Broad st., Westfield
**Mills, Stephen D., Navy**
**Minnella, Thomas J., Navy**
Morris, Karl E., 648 E. Broad st., Westfield
Morris, Thomas M., 505 Park av., Plainfield
Morris, Watson B., 193 Morris av., Springfield
Munger, Ray T., 727 Watchung av., Plainfield
Murphy, Albert T., 1108 Anna st., Elizabeth
Murphy, Herschel S., 320 Chestnut st., Roselle
**Murray, Norman L., Army**
**Nadler, Arthur A., Army**
**Naidorff, Saul A., Army**
Newbury, Graham C., 209 Miln st., Cranford
Nittoli, Rocco M., 660 E. Jersey st., Elizabeth
**Novello, Joseph A., Army**
**Nussbaum, Joseph, Army**
Obester, Gabriel E., 640 N. Broad st., Elizabeth
**O'Brien, Edwin J., Jr., Army**
Oderr, Charles, 302 W. 12th st., New York City
**Orton, Foster, Navy**
Orton, George L., 196 Elm av., Rahway
**Orton, Stuart, Navy**
Osher, Morris M., 157 North av., Fanwood
**Owen, Philip, Army**
Paulson, Arch M., 160 E. 7th st., Plainfield
**Pearl, Sydney S., Army**
**Peters, Richard C., Navy**
Phelan, Walter F., 124 Chilton st., Elizabeth
Poleshuck, Rubin, 100 Hollywood av., Hillside
Polk, Charles C., 114 E. 7th av., Roselle
**Pollack, Louis, Army**
Prazak, Beatrice, 500 Monroe av., Elizabeth
Preminger, Max, 822 Park av., Plainfield
Proudfoot, Perry A., 527 Walnut st., Roselle
Prout, Thomas P., 19 Prospect st., Summit
Quin, John A., 1100 Bryant st., Rahway
**Read, Jessie D., Army**
Reale, Frank P., 1012 Park av., Plainfield
Reich, Jerome J., 1500 N. Broad st., Hillside
Reilly, David F., 44 Prince st., Elizabeth
Reiner, Jacob, 811 N. Broad st., Elizabeth
Reiter, Walter A., 50 DeForest av., Summit
**Relyea, George M., Army**
Robertson, Grace M., 515 W. 7th st., Plainfield
Robinson, Anne W., 177 Outer dr.,OakRidge,Tenn.
Rose, Abraham, 326 S. Broad st., Elizabeth
**Rosenblatt, Max B., Army**
Rosenstein, Saivel L., 2120 Springf'd av., Vauxhall
Roth, Ferdinand L., 1122 Hollywood rd., Linden

Rubin, David, 200 E. Jersey st., Elizabeth
Rumsey, Wm. L., Jr., 399 Westfield av., Elizabeth
Runnells, John E., Bonnie Burn San., Scotch Pl'ns
**Sadoff, Joseph, Army**
Sagi, Ellen I., 376 Elmora av., Elizabeth
Salvati, Leo H., 275 Orchard st., Westfield
**Samuels, S. Lawrence, Army**
**Satulsky, Emanuel M., Army**
Scalessa, Mario F. T., 396 Broad st., Summit
Schenk, Joseph R., 1177 Park av., Plainfield
Schiller, Edwin, 523 Westfield av., Elizabeth
Schiller, Rosa O., 523 Westfield av., Elizabeth
Schilling, Anthony B., 727 Jefferson av., Elizabeth
Schlein, David, 812 N. Wood av., Linden
Schlichter, Chas. H., 556 N. Broad st., Elizabeth
**Schwartz, Samuel H., Army**
**Schweizer, Roman G., Army**
Seeler, Albert O., 236 W. Milton av., Rahway
Sell, Frederick W., 167 W. Emerson av., Rahway
Sena, Dominic R., 1554 Irving st., Rahway
**Senerchia, Fred F., Jr., Army**
**Seybold, Arthur D., Navy**
Seymour, George A., 253 Orchard st., Elizabeth
Shangle, Milton A., 34 Prince st., Elizabeth
**Sherman, Samuel H., Army**
Shirrefs, Russell A., 348 Elmora av., Elizabeth
Sims, Richard V., Jr., 31 Morris av., Summit
Singer, Bella, 640 Wyoming av., Elizabeth
Sly, John L., 382 Springfield av., Summit
**Spirito, Michael W., Army**
**Spivack, David, Army**
Stanton, Nathaniel B., 734 Park av., Plainfield
**Staub, E. Milton, Navy**
Steele, Stephen, 10 West Gibbons st., Linden
Stein, Emil, 607 Park av., Elizabeth
**Stein, George H., Army**
Stein, Isadore, 817 N. Broad st., Elizabeth
Stein, Martin H., 60 Elmora av., Elizabeth
**Steinberg, Werner, Army**
Stephenson, Gordon A., 145 Summit av., Summit
**Stevenson, G. McKay, Army**
**Strauss, Clifton J., Navy**
**Strelinger, Alexander, Army**
Strom, Abraham, 410 W. 7th st., Plainfield
Stuart, J. Earle, 552 E. 2nd st., Plainfield
**Stybel, Joseph, Army**
**Suffness, Gustave, Army**
**Taranto, Michael, Navy**
Tator, Arthur E., 57 DeForest av., Summit
**Terrell, Edward E., Army**
Thompson, Minturn R., 530 W. Broad st., Westf'd
Tidaback, John D., 382 Springfield av., Summit
Tolor, Stanley, 27 Third st., Elizabeth
Tomlinson, Rolland D., 505 E. Broad st.,Westfield
Townsend, Leslie M., 420 Chestnut st., Roselle P'k
Trano, Giovanni, 641 Second av., Elizabeth
**Triarsi, Anthony J., Army**
Tyndall, Alice E., 263 Walnut st., Westfield
Tyndall, Martha W., 263 Walnut st., Westfield
Vinciguerra, Michael, 604 Westm'ster av.,Elizab'h
Vitale, Dominic V., 749 N. Broad st., Elizabeth
**Vitolo, Ralph E., Navy**
Vogel, H. Austin, 1060 E. Jersey st., Elizabeth
**Wacker, William F., Army**
Wade, Simon F., 555 Newark av., Elizabeth
Wagner, Otto, 111 Stiles st., Elizabeth
**Wagner, Richard, Army**
Walsh, Ronald J., 338 S. Broad st., Elizabeth
Walsh, Thomas J., 335 S. Broad st., Elizabeth
Ward, Leo J., 137 W. Jersey st., Elizabeth
Webb, Eleanor A., 887 Springfield av.,NewPr'vid'nce
Wegryn, Louis S., 257 Elizabeth av., Elizabeth
Weigel, Edgar W., 970 Park av., Elizabeth
Weigel, Elmer P., 727 Watchung av., Plainfield
**Weissberg, William W., Army**
Weissman, Meyer T., 1137 E. Jersey st., Elizabeth
**Weltchek, Herbert, Army**
**Western, Frederic B., Army**
**Whinery, Joseph F., Army**
Whitken, Albert I., 1056 North av., Elizabeth
Williams, Frank A., 324 W. Jersey st., Elizabeth
**Williams, Leonard D., Army**
**Williams, Manley C., Navy**
Wolff, Jerome M., 1414 Martine av., Plainfield
Wolgin, Philip L., 445 Elmora av., Elizabeth
Woody, McIver, 19 Pingry pl., Elizabeth
Wuester, William O., 238 Exter way, Hillside
Yagol, Benjamin, Medical Arts Bldg., Tulsa, Okla.
**Yellin, Charles H., Army**
**Yorke, Edward T., Army**
Young, Franklin C., 120 Summit av., Summit
Young, Ralph A., 842 N. Wood av., Linden
**Yuckman, Robert O., Army**
**Yuckman, William, Army**
**Zingales, Joseph A., Army**

**Number of Active Members and basis of representation, 381.**

### HONORARY MEMBERS

Guidi, Guido M., Elizabeth
Shirrefs, Russell A., Elizabeth

### TRANSFERS

Casey, Robert B., from New York
Evans, Joseph O., from Essex County
Fagin, Joseph, to Michigan

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## WARREN COUNTY (21)

Society organized February 15, 1826. Meets on third Tuesday of January, April, July and October, the last being the Annual Meeting.

### ACTIVE MEMBERS

Baldauf, Herman, Jr., Greenwich st., Belvidere
Bloom, G. Homer, Hillcrest av., Phillipsburg
**Boquist, Walter A., Army**
Bossard, Harry B., R. D. No. 2, Phillipsburg
Bostwick, Wallace R., Main st., Blairstown
Brasefield, Edgar N., 218 Chambers st.,Phillipsb'g
**Buchanan, Ralph M. L., Navy**
Drake, Paul F., 85 Summit av., Phillipsburg
Gordon, Frank S., Blairstown
**Humbert, Joseph C., Jr., Navy**

Jackson, Elmer C., Blair Academy, Blairstown
Kassow, Philip B., North Blvd., Alpha
Kimmel, Seymour S., Oxford
Krausz, Emery, 577 S. Main st., Phillipsburg
Lemmon, Junius M., Army
Lyon, Charles H., 79 Lewis st., Phillipsburg
**Marlett, Neumann C., Navy**
**Maxwell, Carl A., Army**
Michell, George E., 221 High st., Hackettstown
**Mitchell, Willis B., Navy**
Potter, Charles W., 184 Belvidere av., Washington
Shevitz, David M., 212 Grand av., Hackettstown
Shimer, Floyd A., 88 Lewis st., Phillipsburg
**Smith, Herman, Army**
**Smith, J. Meredith, Navy**
Spillane, Timothy H., 379 S. Main st., Phillipsburg
Stone, Russell B., 56 Summit st., Phillipsburg
Varney, William H., 122 Belvidere av., Washingt'n
West, Guernsey F., 109 S. Main st., Phillipsburg
West, Heston R., 109 S. Main st., Phillipsburg
Wolf, Frank A., 494 S. Main st., Phillipsburg
Zuck, Arthur C., 22 Broad st., Washington

**Number of Active Members and basis of representation, 32.**

## TRANSFER

McMurtrie, William A., to Morris County

## MEMBERSHIP SUMMARY

| County | TOTAL | | IN SERVICE | |
|---|---|---|---|---|
| | Active | Associate | Active | Associate |
| Atlantic | 122 | 5 | 46 | 3 |
| Bergen | 325 | 6 | 131 | . . |
| Burlington | 71 | . | 22 | . . |
| Camden . . | 206 | . | 82 | . |
| Cape May | 26 | | 5 | . . |
| Cumberland | 61 | | 13 | . . |
| Essex . . . | 1224 | 21 | 407 | 4 |
| Gloucester | 48 | . | 15 | . |
| Hudson . | 489 | . | 155 | . |
| Hunterdon | 30 | | 6 | |
| Mercer . | 241 | 16 | 74 | 5 |
| Middlesex | 180 | 11 | 62 | 3 |
| Monmouth | 137 | 4 | 51 | . |
| Morris . . | 126 | | 44 | . |
| Ocean | 33 | | 16 | |
| Passaic | 388 | 21 | 128 | 11 |
| Salem . | 29 | | 8 | . |
| Somerset . . | 64 | | 24 | . . |
| Sussex . . . . | 31 | . . | 11 | . . |
| Union . . | 381 | | 135 | . |
| Warren | 32 | | 9 | |
| Totals | 4244 | 84 | 1444 | 26 |

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